Radiation Oncology
Dr. William D. Permenter
Dr. Paul Koerner

Notice of Privacy and Patient Consent
For Use and Disclosure of Protected Health Information

Patient Name: ___________________________ Date: _______________

I **understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I **understand** that the Cancer Care Center may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient: handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

I **understand** that I have the right to read the 'Notice' before signing this agreement. If I ask, Cancer Care Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Cancer Care Center to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I have the right to revoke this in writing at any time, except to the extent that Cancer Care Center has taken action relying on this consent.

____ __________

Signature of Patient or Legal Guardian/Authoritative Representative Date

____ __________

Relationship of Patient if signed by another party Date

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our 'Notice' at any time by contacting: Cancer Care Center 322 Hospital Boulevard Jackson, TN 38305. Phone # 1-731-668-1668. Fax # 1-731-668-5801.