



HIPAA PRIVACY AUTHORIZATION FORM

(Health Insurance Portability & Accountability Act)

- I authorize my physician and/or administrative and clinical staff to use my protected health information and disclose the following protected health information to:
 Any/All Family Members Name of Person(s) : _____
- The protected health information to be used or disclosed is:
 All Medical Records Specific Records as listed below:
(Describe the information to be used/disclosed-for example: types of services, any or all laboratory reports, pathology, x-ray reports, progress notes, or "all medical records").

- This protected health information is being used or disclosed for the following purposes:
 At the request of the individual (the patient) or List below the specific purpose for the use or disclosure.

- This authorization shall be in force and effect until at which time this authorization to use or disclose this protected health information is recinded in writing by patient.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Medical Oncology Care Associates at 1010 W. La Veta Avenue, Suite 250, Orange, CA 92868.**
I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that I may obtain a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my heath information.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative

Date

PRINT NAME of Patient or Personal Representative

Relationship to patient
