NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT POLICIES AND PROCEDURES

Your signature below is only acknowledgement that you are aware of the Privacy Practice Policy for Regional Cancer Care Associates effective March 1, 2019.

The above named practice may discuss my treatment with the following people (include any family, friends, or other contacts):

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I may be contacted at the following locations:

___Yes_____No Home #__________________

___Yes_____No Work # __________________

___Yes_____No Cell # __________________

May we leave a message regarding your medical care on your answering machine?_____Yes_____No

Email address____

Print Name ______________________________

Date: ________________________

Signature ____________________________

Your signature below acknowledges that a research nurse may review your records for purposes of providing clinical trial options for your care.

*******If you chose to waive this option please cross off this statement and initial.**______________**********

Signature ________________________________