

Heartland Hematology & Oncology P. C.
412 West 42nd Street Kearney, NE 68845
Phone: (308) 865-2303 Fax: (308) 865-2304

Receipt of Notice of Privacy Practices (HIPAA)
Written Acknowledgement Form

I, _____, have received a copy of Heartland Hematology & Oncology P.C.'s
Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

Recipient. Heartland Hematology & Oncology, P.C., takes patient privacy seriously. HHO personnel use and disclose patient health information only as permitted by HHO policies and applicable law. Such polices and law permit HHO personnel to disclose a patient's health information to friends and family members designated by the patient. This voluntary form allows you to designate the friends and family members to who HHO personnel may disclose information about your health care, as well as the information that may be disclosed. The following persons or organization are to *receive* the personal health information:

Name	Relationship	Phone Number

Explanation of Rights. I understand that:

- I can revoke this authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosure already made and actions already taken in reliance upon this Authorization.
- The disclosing provider may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization.
- I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

Signature of Patient or Personal Representative

Date

Representative's Relationship to Patient (if applicable)

Date

Renewal of Privacy Practice Policy

- I have read and understand the above information and I reauthorize the above people to *receive* health information.

Date/Initials

Date/Initials

Date/Initials

Date/Initials