SONIWALA
HEMATOLOGY-ONCOLOGY
ASSOCIATES
A Roswell Park Community Cancer Practice

UNDERSTAND PREVENT
& CURE CANCER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Private Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Print Name: ______________________________

Sign Your Name: ______________________________

Relationship to the patient: ______________________________

Date: ______________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _________ Initials: _________ Reason: _________________________