DR. MOHTASEB CANCER
CENTER & BLOOD DISORDERS

HIPAA Contact

In order to protect the privacy and confidentiality of your protected health information Dr. Mohtaseb Cancer Center & Blood Disorders staff members are requesting your permission to provide information to individuals other than yourself.

I agree/disagree that information directly related to my healthcare and billing can be released to family members, close personal friends or any other person(s) that are identified below.

I agree/disagree to be contacted by telephone for appointment confirmations, follow up regarding treatment or test results, in an emergency at work, and that you may leave a message on my voicemail.

Please identify individuals that you agree to allow Dr. Mohtaseb Cancer Center & Blood Disorders staff members to communicate healthcare and billing information to.

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

_____

Signature of patient or legally authorized individual Date

_____

Print name of patient or legally authorized individual

_____

Relationship to patient, if signed by anyone other than the patient