Mid-Illinois Hematology & Oncology Associates, Ltd.

ACKNOWLEDGEMENT of RECEIPT of PRIVACY POLICY

I acknowledge that I have been provided a copy of Mid-Illinois Hematology & Oncology Associates, Ltd. Privacy Notice.

_____

Patient Name (Please Print)

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

Please list ALL family members and friends to whom we may release limited information regarding your healthcare. Please be aware that we can provide information about your healthcare such as appointment times, lab results and medications ONLY to people on this list. We will not release any information to anyone without your written authorization.

_____

_____

_____

OFFICAL USE ONLY – TO BE COMPLETED BY STAFF ONLY

Documentation of Good Faith Efforts

Patient Name: _____ Date: _____

The patient presented for his/her procedure on this date and was provided with a copy of Mid-Illinois Hematology & Oncology Associates, Ltd. Privacy Notice. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment was not obtained because:

☐ Patient refused to sign ☐ Patient was unable to sign or initial because: _____

☐ Other reason, described as: _____

Signature of employee completing the form: _____