

# 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.

### OFFICIAL USE 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: \_\_\_\_\_