Hematology Oncology Associates of CNY

Privacy Disclosure Notice Acknowledgement

I, _____, DOB_____, hereby acknowledge that I have received and reviewed a copy of Hematology Oncology Associates of CNY Notice of Privacy Practice.

I understand that the Notice of Privacy Practice may periodically be revised and that I am entitled to request a copy of any revised Notice of Privacy. I also understand that if I have questions or complaints, I may contact:

Mary Stone
Chief Quality Officer
Hematology Oncology Associates of CNY
315-472-7504

You may also contact the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to reach the DHHS.

Patient or Personal Representative

Signature: _____ Today's Date:_____/_____/____

Name: (Please Print) _____

Relationship to Patient:_____

For Office Use Only

We made a good- faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practice. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply)

__ Patient refused to sign (date of refusal) ___/___/___

__ Communications barriers prohibited obtaining an acknowledgement

__ Other _____

4/2013/ 1/2017, 1/21/2019