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## PRIVACY PRACTICES ACKNOWLEDGMENT

### Consent for Uses/Disclosures of PHI for Treatment, Payment, Healthcare Operations

A copy of Carolina Regional Cancer Center's *Notice of Privacy Practices* has been provided to me. I understand that I have a right to review the *Notice of Privacy Practices* prior to signing this document.

The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills and/or in the performance of healthcare operations of CRCC. It describes my rights and CRCC's duties with respect to my PHI. CRCC reserves the right to change the privacy practices that are described in the *Notice*. I may obtain a revised notice of privacy practices by accessing CRCC's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my PHI by CRCC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills and/or to conduct healthcare operations of CRCC. I understand that diagnosis or treatment of me by CRCC may be conditioned upon my consent as evidenced by my signature on this document.

I also consent to have CRCC obtain from any other medical facility or organization my medical and/or financial records pertinent to my treatment.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that CRCC and its staff has taken action in reliance on this consent.

Patient / Patient's Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

Signed copy given to patient. CRCC Initials: \_\_\_\_\_