Methodist
RICHARDSON HEMATOLOGY
ONCOLOGY ASSOCIATES

PATIENT CONSENT FOR DISCLOSURE OF HEALTHCARE INFORMATION FORM

Methodist Richardson Hematology Oncology Associates Notice of Privacy Practices (the "NOTICE") provides information about how Methodist Richardson Hematology Oncology Associates may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. A copy of the current Notice is posted in the waiting room. The Notice contains on the first page, in the top right-hand corner, the effective date. As provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____
Print Patient's Name

_____ _____
Signature (and relationship if not patient) Date

_____
Witness