UHO
UPSTATE HEMATOLOGY ONCOLOGY
at Community Care Physicians

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A Touch of Healing

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Patient Privacy Disclosure Form

Patient Name: _____
Patient Date of Birth: _____
Patient Signature: _____
Today's Date: _____

Please circle Yes or No for each of the following lines:

- I give Upstate Hematology Oncology permission to contact me at home, at work or on my cell phone.
  My phone number/numbers: Home: _____ Yes or No
  Work: _____ Yes or No
  Cell Phone: _____ Yes or No

- If I am not home, at work or available on my cell phone, I give Upstate Hematology Oncology permission to leave messages on the following answering machines or voicemails:
  Home: _____ Yes or No
  Work: _____ Yes or No
  Cell Phone: _____ Yes or No

- I give Upstate Hematology Oncology permission to share information (i.e. billing, appointment. insurance and medical information) with the following people:

  Name: _____
  Relationship: _____
  Telephone Number/s: _____
  _____

  Name: _____
  Relationship: _____
  Telephone Number/s: _____
  _____

  Name: _____
  Relationship: _____
  Telephone Number/s: _____
  _____