Virginia Cancer Care

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Fax 703-729-1446

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Suite 260
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Phone 703-794-4400
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NOTICE OF PRIVACY PRACTICES CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I understand that this organization has the right to change its privacy practices at anytime and that I may contact this practice at anytime at the above addresses to obtain a copy of the current "*Notices of Privacy Practices".*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care opertations. I also understand that you are not required to agree to my restrictions, but it you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____ Date:_____

Updated 5/25/2017