ARIZONA ONCOLOGY
United in Healing with The US Oncology Network

CONTACT LIST

The purpose of this form is to provide Arizona Oncology with the names of people to be contacted on your behalf. You can select two different contact types.

HIPAA: Indicate any person to whom you authorize the release of information related to your medical condition. Physicians involved with your medical care don not need to be included here.

Emergency: Indicate any person whom should be notified in case you experience a medical emergency while at our office.

You can indicate a contact as both HIPAA and Emergency if you choose.

Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
☐ HIPAA ☐ Emergency	
Contact Name:	Relationship:
Primary Phone Number	Alternate Phone Number
☐ HIPAA ☐ Emergency	
Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number
☐ HIPAA ☐ Emergency	
Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
☐ HIPAA ☐ Emergency	

1. I hereby authorize Arizona Oncology to use and disclose my personal health information to the individuals identified on this form as HIPAA contacts.
2. I understand that the individuals identified on this form as HIPAA contacts will be treated by Arizona Oncology as individuals involved directly in my care and as such Arizona Oncology will be allowed to release my personal health information to these individuals for the purposed of treatment, payment and health care operations.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from Arizona Oncology.

THIS AGREEMENT / CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Arizona Oncology will not be affected if I refuse to sign this authorization.

_____ _____
Patient Signature Date / Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date / Time AM or PM (circle one)

PHYSICIAN: _____ EMPLOYEE INITIALS

MRN: _____ LOC: _____ _____

Original - Medical Record Copy - Patient or Personal Representative