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Fairbanks CancerCare Physicians P.C.

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HIPAA Privacy Consent Form

This consent form allows Fairbanks Cancer Care Physicians, P. C. to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Fairbanks Cancer Care Physicians, P. C. has provided me with Notice of Privacy Practices, which more completely describes such uses and disclosures. I was provided this notice prior to my signing this form in accordance with my right to review its practices before signing this consent. **Initials** _____

I understand that Fairbanks Cancer Care Physicians, P.C. participates in utilizing The Alaska eHealth Network Exchange to improve the safety and quality of my healthcare and I have the option to opt out by selecting the box below and opting out at http://www.ak-ehealth.org/for-patients/what-are-my-options-for-participation/

☐ I elect not to participate in the Alaska eHealth Network Exchange. By checking this box, I understand that further action is required and I must opt-out via the Alaska eHealth Network website.

I understand that the terms of the Notice Of Privacy Practices may change and that I may obtain revised notices by U.S. Mail, at the address I provide.

I understand that I have the right to request—now and in the future—how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while Fairbanks Cancer Care Physicians, P. C. is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Fairbanks Cancer Care Physicians, P.C. may refuse me services if I refuse to sign this consent.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Fairbanks Cancer Care Physicians, P. C. may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that Fairbanks Cancer Care Physicians, P.C. may refuse further service if I revoke this consent.

I hereby authorize Fairbanks Cancer Care Physicians to send electronic prescription requests, to receive electronic prescription refill requests and to download prescription history as necessary.
Yes ☐ **No** ☐

Patient Name: _____
(Please Print)

Name of Legal Representative (if applicable): _____
(Please Print)

Specify relationship or, authority to act for, individual (if applicable): _____

Signature of Patient or Legal Representative: _____ **Date:** _____

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