MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date _____ **Patient Name** _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative **Print Name of Patient or Personal Representative**

_____

Description of Personal Representative's Authority

Contact Information for Personal Representative:

Address:

_____

_____

Phone Number:

_____ _____

Daytime **Evening**

I authorize Mid Florida Hematology and Oncology Centers, P.A. to share my medical information with the following:

_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**

This authorization will remain in effect from the date it is signed until I cancel it in writing.

By signing below, I acknowledge I have reviewed and understand this authorization form.

_____ _____

Patient Name **Date**

1070 N. Stone Street, Suite C, Deland, FL 32720 (T) 386-734-1013 (F) 386-734-1028
2776 Enterprise Road, Suite 100, Orange City, FL 32763 (T) 386-774-1223 (F) 386-774-4658
2100 W. First Street, Sanford, FL 32771 (T) 407-323-2250 (F) 407-321-5550