

## Arizona Oncology Associates, P.C.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona Oncology Associates, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona Oncology Associates, P.C.

Patient or Personal Representative Name (printed): \_\_\_\_\_

Patient or Personal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
For Office Use Only:

Reason acknowledgement was not obtained:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN: _____
MRN: _____ LOC: _____

EMPLOYEE INITIALS \_\_\_\_\_