



**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT  
AND PATIENT POLICIES AND PROCEDURES**

Your signature below is only acknowledgement that you are aware of the Privacy Practice Policy for Regional Cancer Care Associates effective March 1, 2019.

The above named practice may discuss my treatment with the following people (include any family, friends, or other contacts):

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

I may be contacted at the following locations:

\_\_\_ Yes \_\_\_ No Home # \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No Work # \_\_\_\_\_  
\_\_\_ Yes \_\_\_ No Cell # \_\_\_\_\_

May we leave a message regarding your medical care on your answering machine? \_\_\_ Yes \_\_\_ No

Email address \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

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

***Your signature below acknowledges that a research nurse may review your records for purposes of providing clinical trial options for your care.***

***\*\*\*\*If you chose to waive this option please cross off this statement and initial. \_\_\_\_\_ \*\*\*\****

\_\_\_\_\_  
Signature