HHO HUNTERDON BLOOD & CANCER SPECIALISTS

2100 Wescott Drive, Flemington, NJ 08822
P: 908-237-1201 F: 908-237-1210
www.HunterdonHematologyOncology.com

Privacy & Release Information

Patient Bill of Rights

I understand that if I am enrolled in a managed care insurance program, it is my responsibility toobtain and bring a referral from my primary care physician (PCP) for all medical services. Any service rendered without referral will become my financial responsibility. I acknowledge that I have discussed my insurance with this office and understand that charges will be filed with my insurance carriers and any deductibles, coinsurance or co-payments will be my responsibility.

_____
Patient initials

Release of Information

I hereby authorize Hunterdon Hematology Oncology, LLC (HHO) to apply for benefits on my behalf for services. I request that payment from my insurance company be made directly to the provider. I authorize the release of medical and insurance information necessary to process claimsand a copy of this authorization may be used in place of the original.

_____
Patient initials

Privacy Notice

I acknowledge receipt of the Hunterdon Healthcare System and Hunterdon Hematology Oncology, LLC's Notice of Practice Privacy Statement which is posted in the waiting area.

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Patient initials

Research Release

I hereby authorize Hunterdon Hematology Oncology, LLC to use my information for potential research.

_____
Patient initials

Shared Electronic Medical Records

I wish to share limited medical information with practices affiliated with Hunterdon HealthcareSystems.

_____
Patient initials

My signature indicates my acknowledgement that all information contained on this form is accurate and true.

_____ _____
Patient Name **Date of Birth**

_____ _____
Patient Signature **Date Signed**