Advanced Oncology Center, Inc.

2707 East Valley Blvd., Suite 109
West Covina, CA 91792
Ph: (626) 956-8009
Fax: (626) 956-8010

Consent for Purpose of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by Advanced Oncology Center, Inc. (AOC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my imaging services or to conduct health care operations of AOC.

I understand that diagnosis or treatment of me by an AOC physician or any of their agents may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. AOC is not required to agree to the restrictions that I may request. However, if AOC agrees to the restrictions that I request, the restriction is binding on AOC.

I have the right to revoke this consent, in writing, at anytime, except to the extent that AOC has taken in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my referring physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health care information relates to my past, present or future physical or mental health or condition and identifies and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Advanced Oncology Center, Inc. Notice of Privacy Practices* prior to signing this document. *Advanced Oncology Center, Inc. Notice of Privacy Practices* has been provided to me.

The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of Advanced Oncology Center, Inc. The *Notice of Privacy Practices* for this center is available in the lobby of this office. AOC reserves the right to change the privacy practices that are described in the *Notices of Privacy Practices.*

I may obtain a revised *Notice of Privacy Practices* by calling this office and requesting a revised copy be sent in the mail or requesting for at the time of my next appointment

I also understand that Medical Doctors are licensed and regulated by the Medical Board of California (800) 633-2322 (www.mbc.ca.gov).

Patient
Signature: _____ Date:_____
Patient Name: _____

_____ _____
Legal guardian or Patient's Personal Representative Relationship to Patient