BUX-MONT ONCOLOGY HEMATOLOGY MEDICAL ASSOCIATES, PC

Alan Kaufman, M.D.   Thomas Siesholtz, M.D.   Mitchell Alden, D.O.   Howard Zipin, M.D
Anthony Magdalinski, D.O. Lorraine Dougherty, M.D.
Thomas Peacock, M.D..

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Bux-Mont Oncology Hematology Medical Associates to use and disclose health information about you for treatment, payment and health care operation purposes

Notice of Privacy Practices. Bux-Mont Oncology Hematology Medical Associates, PC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:
Mail: Bux-Mont Oncology Hematology Medical Associates, PC
Attn: Privacy Officer
The Summit, 920 Lawn Avenue, Sellersville, PA l8960
Telephone: (215) 453-3300
Facsimile: (215) 453-3306

Acknowledgement and Consent

(*Print or type all information except the signature*)

I have received the Notice of Privacy Practices for Bux-Mont Oncology Hematology Medical Associates, PC. Bux-Mont Oncology Hematology Medical Associates, PC is authorized to use and disclose health information about __________________________ (patient name) for treatment, payment and healthcare operation purposes consistent with its Notice of Privacy Practices.

____   ________________________
Signature of Patient or Personal Representative   Date

Personal representative information (if applicable)

____________________________   _________________________
Name of personal representative   Relationship to patient (or other authority

Sml 2/27/03 updated 06-11-08