Hematology & Oncology
RHODE ISLAND

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Patient's Name: ____

ID Number: ______________________________

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Hematology & Oncology Associates of Rhode Island, Inc.

____ ______________
Signature of Patient or Representative Date

____
Printed Name of Patient or Representative

____
Relationship of Representative

REPRESENTATIVE INFORMATION

The contact information of the representative who signed this form should be filled out below:

Address: ____

City, State, Zip Code: ______________________________________

Telephone: (_____) __________________ Alt. Telephone: (_____) ____________