Florida Oncology Tavares
RADIATION TREATMENT CENTER

HIPAA – Others Involved In Health Care

As a patient of Florida Oncology Tavares, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. The information provided on this page will be valid for one year from the date of signature. This information can be changed or revoked with your permission at any time.

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

I give permission for information related to my current health status to be discussed with:

_____
Name Relationship Telephone

_____
Name Relationship Telephone

_____
Name Relationship Telephone

_____
Name Relationship Telephone

_____
Name Relationship Telephone

Patient Name: _____ **Date of Birth:** _____
Print Name

Signature: _____ **Today's Date:** _____
Patient or Legal Representative