Beacon Infusion
Healthcare Services

Headquarters Location:
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PRIVACY PRACTICES ACKNOWLEDGEMENT

♦ Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees, their staffs and providers may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations (TPO). I understand and acknowledge that Beacon Infusion Healthcare Services LLC's Notice of Privacy Practices has a more complete description of such uses and disclosures.

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand and acknowledge that Beacon Infusion Healthcare Services LLC reserves the right to revise its Notice of Privacy Practices at any time, and that a revised version of that notice may be obtained sending a written request to the Privacy Officer at the practice.

♦ I permit Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees to leave telephone messages regarding my appointments, prescription renewals, lab results, and all other PHI, may be left for me on voicemail systems and answering machines, or given the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

♦ I agree that my PHI may be shared with my spouse (if applicable).

♦ I agree that my PHI may be shared with my other medical providers.

♦ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

♦ I agree that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may use my information including PHI for operational, fiscal, promotional and development purposes.

♦ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Beacon Infusion Healthcare Services LLC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

♦ I agree that my PHI may be shared with my credit card vendor(s) to permit Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees to submit records to support its charges if needed.

♦ I agree that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly):_____

Signature of Patient: _____ Date: _____