ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S. Dr. Paul M. Goldfarb, M.D., F.A.C.S.

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Oncology Associates of San Diego herein known as "Health Care Provider", for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of "Health Care Provider".

I understand that diagnosis or treatment of me by "Health Care Provider" 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. "Health Care Provider" is not required to agree to the restrictions that I may request. However if "Health Care Provider" agrees to a restriction that I request, the restriction is binding on "Health Care Provider" and "Health Care Provider" practice.

I have the right to revoke this consent in writing, at any time, except to the extent that "Health Care Provider" has taken action 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 physician, another health care provider, a health plan, my employer or a healthcare clearinghouse.

This protected health information relates to my past present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that information may identify me.

I understand I have a right to review "Health Care Providers" Notice of Privacy Practices prior to signing this document.

The "Health Care Providers" Notice of Privacy Practices has been provided to me.

The notice Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of "Health Care Provider".

The Notice of Privacy Practices for "Health Care Provider" is also provided in the Reception Area and on the ""Health Care Provider" web site at www.westcoasthipec.com.

This Notice of Privacy Practices also describes my rights and the duties of "Health Care Provider" with respect to my protected health care information.

"Health Care Provider" reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by accessing the "Health Care Providers" Web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

_____

Description of Patient or Personal Representative