Alaska Oncology and Hematology, LLC

Mary Stewart, MD
Verneeda Spencer, MD
Max Rabinowitz, MD
Steven Liu, MD
Zach Zipsir , PA

2741 DeBarr Road, Suite C-405
Anchorage, Alaska 99508

YOUR RIGHT TO PRIVACY

PATIENT NAME____________________________________**DATE OF BIRTH**_______________

If you'd like to share your information with your spouse, partner, significant other, friend, or family members, list them below:

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PLEASE NOTE: THESE WILL BE THE ONLY PEOPLE BESIDES YOURSELF WHO ARE ABLE TO RECEIVE INFORMATION ABOUT YOUR CONDITION.

We respect your right to privacy regarding, medical information. Without additional written consent we cannot share your information. Please keep in mind; you are responsible to update this form with any changes. This form is valid until otherwise notified by you in writing.

I hereby authorize Alaska Oncology and Hematology, LLC to send electronic prescription requests, to receive electronic prescription refill requests and to download prescription history as necessary. ☐YES ☐NO

ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge the
Receiving Alaska Oncology and Hematology, LLC
Notice of Privacy Practices.

____ ______________________
PATIENT SIGNATURE **DATE**

Alaska Oncology and Hematology is researching new methods of prevention, diagnosis and treatment of cancer. By signing below I authorize a protocol nurse to review my chart to determine if I am eligible to participate.

____ ______________________
Patient Signature **Date**