ACKNOWLEDGEMENT/RECEIPT OF PRIVACY PRACTICES FOR

LAKE ORION-ROCHESTER ONCOLOGY

Malgorzata Sobilo, MD., P.C.
720 N Lapeer rd Ste 102
Lake Orion, MI 48362

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information to anyone other than as listed below. You may edit who has access to your information at any time.
- For more information visit: www.hhs.gov/ocr/privacy/hipaa

By signing below, I acknowledge that I have been informed about the privacy from Lake Orion-Rochester Oncology.

Patient Signature: ___________________________________ Date: _____________________________

Witness Signature: __________________________________ Date: _____________________________

Please list (print) names of any family members or any other person(s) you may want our facility to release your health information to (excluding other physicians).

Name:_____________________________ Relation______________ Phone #: ______________________

Name:_____________________________ Relation______________ Phone #: ______________________

Name:_____________________________ Relation _____________ Phone #: _______________________

Documentation of Failure to Obtain Signed Acknowledgement

On _________(Date), ______________________ (Name of Employee) presented this acknowledgment of Receipt of Notice of Privacy Practices Form to ___________________(Patient's Name). The patient refused to provide a signature when requested.