



Privacy & Release Information

Patient Bill of Rights

I understand that if I am enrolled in a managed care insurance program, it is my responsibility to obtain and bring a referral from my primary care physician (PCP) for all medical services. Any service rendered without referral will become my financial responsibility. I acknowledge that I have discussed my insurance with this office and understand that charges will be filed with my insurance carriers and any deductibles, coinsurance or co-payments will be my responsibility.

Patient initials

Release of Information

I hereby authorize Hunterdon Hematology Oncology, LLC (HHO) to apply for benefits on my behalf for services. I request that payment from my insurance company be made directly to the provider. I authorize the release of medical and insurance information necessary to process claims and a copy of this authorization may be used in place of the original.

Patient initials

Privacy Notice

I acknowledge receipt of the Hunterdon Healthcare System and Hunterdon Hematology Oncology, LLC's Notice of Practice Privacy Statement which is posted in the waiting area.

Patient initials

Shared Electronic Medical Records

I wish to share limited medical information with practices affiliated with Hunterdon Healthcare Systems.

Patient initials

My signature indicates my acknowledgement that all information contained on this form is accurate and true.

Patient signature

Date