Virginia Oncology Associates

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

Name (PRINT): _____

SSN: _____

According to our Notice of Privacy Practices, we may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. If you would like us to refrain from releasing your health information to a family member or friend, please list the name(s) of who you **DO NOT** want your private health information released to on the lines below. Remember, in the future, if there are additions to this list, please notify the VOA staff. Thank you.

_____

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_____

Signature:_____ Date: _____