LAS VEGAS CANCER CENTER

CONFIDENTIALITY FORM

Please understand that is the goal of Las Vegas Cancer Center to ensure that our patient's privacy is held in the strictest of confidence. **Please carefully read the following information.**

The purpose of this form is to give authorization to family, friends, or a legal guardian to discuss your medical status, such as: diagnosis, chemotherapy treatments, complications, diagnostic testing, prognosis and any questions related to your condition.

Much of the information will be by telephone conversations with doctors, nurses, physician assistants or office staff.

Authorized persons will be required to have a "CODE" number. The code number will be the **last four digits of your social security number**. If the person inquiring about you does not have the "CODE" number, **no information will be released by telephone, fax or mail**.

Please list the name(s) and relationships of ALL persons authorized. If no person is to be given this information, then initial **"ALL PERSONS DENIED"**.

NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____

Patient Signature: _____ Date: _____

Witness _____ Date: _____

ALL PERSONS DENIED _____ Date: _____