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**Patient Privacy Disclosure Form**

Patient Name: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_  
Patient Signature: \_\_\_\_\_  
Today's Date: \_\_\_\_\_

**Please circle Yes or No for each of the following lines:**

- I give Upstate Hematology Oncology permission to call me at home, at work or on my cell phone.  
My phone number/numbers: Home: \_\_\_\_\_ Yes or No  
Work: \_\_\_\_\_ Yes or No  
Cell Phone: \_\_\_\_\_ Yes or No
  
- If I am not home, at work or available on my cell phone, I give Upstate Hematology Oncology permission to leave messages on the following answering machines or voicemails:  
Home: \_\_\_\_\_ Yes or No  
Work: \_\_\_\_\_ Yes or No  
Cell Phone: \_\_\_\_\_ Yes or No
  
- I give Upstate Hematology Oncology permission to send a note or letter to my home address or P.O. Box. Yes or No
  
- I give Upstate Hematology Oncology permission to share information (i.e. billing, appointment, insurance and medical information) with the following people:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone Number/s: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone Number/s: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Telephone Number/s: \_\_\_\_\_

