Solano Hematology Oncology, Inc.
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Phone (707) 446-1114
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Chainarong Limvarapuss, M.D.
Walailuk Chaiyarat, M.D.
Ann M. Wexler, M.D.

PATIENT NAME: ____ **DATE OF BIRTH:** ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

I understand that a copy of the current policies will be available to me upon request at the reception desk at SOLANO HEMATOLOGY ONCOLOGY and CANCER TREATMENT CENTER OF VACAVILLE and/or by mail.

____ ______________________
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

____ ______________________
(Printed Name) (Relationship to Patient)