ACADEMIC UROLOGY

HIPAA Patient Consent Form

I, _____, (date of birth:_____, understand that as part of my health care, AU originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that AU reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

_____ _____

Signature of Patient (or Patient's Legal Representative) Date

_____ (***Initial)*** I agree to allow AU physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____Home # _____ _____cell #_____ _____Work #_____

____(***Initial)*** **No,** I do not agree to allow AU physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____ (***Initial)*** I agree to allow AU physicians and healthcare staff to speak with only the following people regarding my Protected Healthcare Information.

List Name(s), relationship and phone number:

_____

(print name) (relationship) (phone number)

_____

(print name) (relationship) (phone number)

_____ _____ _____

Patient Name (Please Print) Patient Signature Date

☐ Patient Refused to Sign: Staff Name/Date: _____