PRIVACY AUTHORIZATION & VERIFICATION

Ed Herrman, MD **Austin G. Hill, MD**
Alan K. Miller, MD **Bino G. Rucker, MD**
Mark Weintraub, MD **Mitch Yadven, MD**

200 3rd Ave. West, Suite 210, Bradenton, FL 34205 ph. (941) 792-0340 **www.urology-partners.com**

Patients (*Please Print*) Name: _____ _____ _____
First Middle Last

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review and answer the following carefully.

1) Is it **OKAY** to leave a detailed message on your answering machine? YES / NO

2) If **NO**, please let us know how you wish to be notified by our office:

_____

_____

3) Is it **OKAY** to release information to anyone other than you? YES / NO

4) If **YES**, please list each person:

Name _____Relationship _____ Phone ( ) _____

Name _____Relationship _____ Phone ( ) _____

(WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED)

This is also to inform you that Protective Health Information (PHI) may be used and disclosed by the covered entity, which include Drs. Offices, insurance companies, home health agencies, and entities necessary to carry out your treatment, payment, or health care operations. This allows us to provide / obtain information to covered entities for continued treatment. You have the right to request restrictions on uses and disclosures of PHI for treatment, payment, and health care operations purposes. The covered entity is not required to comply with the individual's request, but if the covered entity does agree to the request, the restriction is binding on the covered entity. You have the right to revoke this consent in writing, except to the extent that the covered entity has taken action in reliance on the consent. The terms of this consent are subject to change if new HIPAA (Health Insurance Portability and Accountability Act), rules are implemented.

This is to verify that I have read and understand the above information by signing this statement and, I am giving Urology Partners PA staff consent to release my personal information as described above.

Patient or Legal Guardian signature: _____ Date: _____