FLORIDA UROLOGY PARTNERS, LLP.

HIPAA PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- ✓ The patient understands that:
- ✓ Protected health information may be disclosed or used for treatment, payment or health care operations.
- ✓ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ✓ The Practice reserves the right to change the Notice of Privacy Policies.
- ✓ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- ✓ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ✓ The practice may condition treatment upon the execution of this consent.

Patient: DOB: ge: Account #:

This Consent signed by: Patient Signature:_____ Date: ____/____/_____

Other Name: _____Relationship to Patient: _____

Signature:_____ Date: ____/____/_____

Family members or other persons, if any, we may inform of your general medical condition and diagnosis (including treatment, payment, and healthcare operation):

Name: _____ Phone #: [_____] _____/_____

Name: _____ Phone #: [_____] _____/_____

Name: _____ Phone #: [_____] _____/_____

Please list family members or other persons, if any, we may inform of your general medical condition **ONLY IN EMERGENCY:**

Name: _____ Phone #: [_____] _____/_____

Name: _____ Phone #: [_____] _____/_____

Address for billing and/or correspondence if other than your home: Name: _____

_____City_____State_____Zip_____

Phone # where you want to receive calls about appointments, lab or x-ray test, or other health care information.

[_____]_____/_____ [_____]_____/_____ [_____]_____/_____

Would you like all correspondence marked "Personal and confidential"? _____Yes _____No

Can confidential messages be left on your telephone voicemail? _____Yes _____No