PATIENT PRIVACY POLICY

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

Your protected health information will be used by UROLOGY NEVADA or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

UROLOGY NEVADA is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the *Notice of Privacy Practices* folders located throughout the lobby. **Copies are available by request from the front desk AND are posted on our company website.**

You may revoke this consent at any time; however, UROLOGY NEVADA requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocations will not affect the use and disclosure prior to the date of your request. UROLOGY NEVADA reserves the right to change or modify the privacy practices outlined in the *Notice of Privacy Practices* folders and will notify you of any changes of privacy practices either by mail, at your next appointment, or other pre-approved method you request.

***Acknowledgment**: I have reviewed this consent form and the Notice of Privacy Practices and give my permission to UROLOGY NEVADA to use and disclose my health information in accordance with the consent and notice provided*.

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the following notice.

We will require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

Please indicate to whom you would like to release your personal medical information:

[ ] My spouse [**X**] My Insurance company

[ ] My family members [ ] My doctors

[ ] Other (please specify): _____

ABOVE AUTHORIZATIONS ARE REVOCABLE AT ANY TIME

_____ _____

Patient Name (print) Legal Guardian Name (print)

X_____ _____

Patient / Guardian (Signature) Date