CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information (PHI) will be disclosed or used by Advanced Urological Care for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

___ Yes, the doctor's office may email me.

___ Yes, the doctor's office may leave messages on my answering machine/voice mail.

___ No, do not leave messages. ___ I have no answering machine.

In some cases, it is helpful for a spouse, family member, or trusted friend to be informed of your medical care, to include test results. Pease mark yes or no below.

___ No, do not discuss my medical care with anyone other than myself.

___ Yes, your office may discuss my medical care with the following people:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Signature of Patient/Guardian _____ Date _____