UROLOGY
SURGICAL CONSULTING, PC
Comprehensive Urological Care & Robotic Surgery

Health Insurance Portability and Accountability Act (HIPAA) Form

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Urology Surgical Consulting, PC (USC) , have been offered a copy of the Notice of Privacy practice which describes my privacy rights in accordance with federal and state requirements. I understand my rights according to this policy and that HIPAA law grants Urology Surgical Consulting, PC authorization to use and disclose my medical records for treatment/care and payment operations.

□ Privacy Policy refused by patient/guardian
Reason:

_____ _____ _____
Signature of Patient or Authorized Representative Date

Communication Authorization

I understand that I may be contacted by Urology Surgical Consulting PC on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages and/or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services.

Provider may contact me at home/work phone numbers or my home address regarding my diagnosis, results, treatment and care or payment.

☐ **Yes**, you may call or text my cell phone at: _____.

☐ **Yes**, you may call my home phone number at: _____.

☐ **No**, please **do not** contact me by the following means: _____.

I authorize my provider and the appropriate staff to share medical/billing information about my care/account with the following individual(s) as indicated below:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____

Communication authorization shall expire under any circumstances as listed below:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient or legally responsible person.
3. In the case of a minor having reached the age of majority.

It is the patient's responsibility to notify Urology Surgical Consulting PC of any changes to this form.

_____ _____
Print Patient's Name Home/Cell Phone Number (Please circle)

_____
Patient's Date of Birth

_____ _____
Patient or Legally Responsible Person's Signature Date Witness Date

Rev 09/26/17