UROLOGY GROUP of PRINCETON

134 STANHOPE STREET

PRINCETON, NJ 08540

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPAA, requires that we have your consent prior to our healthcare professional discussing your personal health with your family members or significant others that are not directly involved in your care.

Can our physicians discuss your healthcare with any of your family members? ____ Yes ____ No

Please circle those that apply

Spouse Mother Father Sister Brother Child Other

Provide Name, Relationship, and Telephone # of designated contact:

I hereby give my permission to the Urology Group of Princeton, allowing for the physicians or their representatives to release or discuss authorized medical information and/or billing issues, with the above family members or to leave a voicemail message at the designated phone number where appropriate.

Leave Voicemail (Home / Cell) Discuss Billing Issues with Family Member

__ Yes __ No __ Yes __ No

Please indicate a specific family member if desired _____

This authorization will be in effect until such time as you request its revision. Release of Patient Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

You do not have to sign this authorization in order to receive treatment from the Urology Group of Princeton. You have the right to revoke this authorization in writing to the extent that the practice has acted in reliance upon this authorization; your written revocation must be submitted to the Privacy Officer at 134 Stanhope Street, Princeton, NJ 08540.

PRINT NAME _____

SIGNED BY_____ DATE _____