Urology Group of Princeton

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) Yes No

Discuss billing issues with designated person(s) 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.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that as a part of my medical services, Urology Group of Princeton documents and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence for healthcare professionals

I have received a copy of the Urology Group of Princeton's Notice of Privacy Practices, and give my consent for the practice to use and disclose my PHI.

_____ Signature of Patient or Responsible Party

_____ Print Name of Patient

_____ Relationship/Authority of Responsible

_____ Date