

UROLOGY CONSULTANTS  
**PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by UROLOGY CONSULTANTS of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that UROLOGY CONSULTANTS has the right to change its *Notice of Privacy Practices* from time-to-time and that I may contact UROLOGY CONSULTANTS at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that UROLOGY CONSULTANTS restrict how my private information is used or disclosed to carry out treatment, payment or to obtain care operations. I also understand UROLOGY CONSULTANTS is not required to agree to my requested restrictions but if UROLOGY CONSULTANTS does agree then UROLOGY CONSULTANTS is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that UROLOGY CONSULTANTS has taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_