UROLOGY ASSOCIATES LLC
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You may refuse to obtain a copy of the privacy practice. By signing you are also in acknowledgement that you have received/denied a copy of this office's Notice of Privacy Practices based on your decision.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

I give my permission to disclose my health care information to these individuals:

Name Relationship Name Relationship

____

Name Relationship Name Relationship

I **DO / DO NOT** (circle one) give my permission to leave messages on voicemails associated with the phone numbers that I have provided about my healthcare.

____ __________________
Patient's Signature or Signature of Patient's Representative Date

____ _______________________
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Dan McGinnis, Practice Administrator

Practice Address: 2525 W University Ave, Suite 504 Muncie, IN 47303 MAIN OFFICE

Phone: 765-289-7444 Fax: 765-289-8538 EMail:dmcginnis@urologyassoicateseci.com