Z UROLOGY

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(954) 714-8200 Phone (954) 714-8222- fax
www.ZUROLOGY.COM

HIPAA Authorization

PATIENT'S FULL NAME_____

SOC SEC #_____ BIRTHDATE_____ PHONE _____ E-MAIL_____

STREET _____STATE ____ ZIP _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) _____ will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).
If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize _____to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Z Urology if this authorization information changes.

It is ok to leave confidential medical information for me on my:
[] Home telephone/message _____
[] Work telephone _____
[] Mobile telephone _____
[] Home Facsimile _____
[] Work Facsimile _____

It is okay to give confidential medical information to my:
(List specific names)
[] Spouse _____
[] Parent(s) _____
[] Son/daughter _____
[] Brother/Sister _____
[] Other (name required) _____

I authorize this information to be disclosed in the following ways:
[] Written/photocopy/paper _____
[] Verbal _____
[] Facsimile _____

Dates of treatment: From _____ to:_____

Specific description of the protected health information that I authorize for disclosure
(Authorization to disclose psychotherapy notes must be separate):
[] Progress notes
[] Discharge summary
[] X-ray films or other images
[] Laboratory reports
[] Radiology reports
[] Photographs/videotapes
[] Operative reports
[] Records from other facilities
[] Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
[] Other

I give specific authorization to disclose the following information:
[] HIV test results
[] Documentation of AIDS diagnosis
[] Psychiatric/mental health treatment records

Please indicate/describe each authorized purpose of the use or disclosure:
[] At the request of the individual (patient)
[] Other
_____
_____
_____
_____

I understand that this authorization will automatically expire in 6 months unless otherwise specified: _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Relationship or Authority of Personal Representative (if applicable)_____

Signature of Legal Representative: _____Date: _____

Print Name: _____

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HIPAA CONSENT

Patient Consent for use and Disclosure of Protected Health Information

With my consent, **Z Urology** May use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Z Urology Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that **Z Urology** reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, **Z Urology**, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076.

With my consent, **Z Urology** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Z Urology** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Z Urology** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Z Urology** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to **Z Urology** use and disclosure of my PHI to carry out TPO.

At any time, I may revoke my consent in writing, by sending a signed and dated written statement to Privacy Officer, **Z Urology**, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076, saying that I am revoking my authorization to disclose health records, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent **Z Urology** may decline to provide treatment to me.

Patient's Name (Printed) _____

Signature (of Parent or Legal Guardian for Minors)_____

Parent or Legal Guardian Name (Printed) _____

Relationship or Authority of Personal Representative (if applicable)_____

Date_____

If patient is less than 18 years of age, or can't legally sign for himself/herself, his/her parent's or legal guardian's signature is required.