UROLOGY

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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) _____

Patient Signature *(OR Parent / 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.