MidLantic UROLOGY
Exceptional Care. Personal Service.

HIPAA Patient Consent Form

I, , understand that as part of my health care, MU originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication 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 provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I further understand that MU reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

Patient Signature: _____ Date: _____Date of Birth:_____

_____ (Initial) I agree to allow MU physicians and healthcare staff to leave messages that include Protected Health Information of the following: Please initial next to the applicable communication devices:

Home # _____ Cell # _____ Work # _____

_____ (Initial) No, I do not agree to allow MU physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work, and cell phone.

_____ (Initial) I agree to allow MU physicians and healthcare staff to speak with only the following people regarding my Protected Healthcare Information.

_____ (Initial) I agree to allow MU physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

List Name(s), relationship, and phone number

(print name) (relationship) (phone number)

(print name) (relationship) (phone number)

Patient Name (Please Print) Patient Signature Date

Patient Refused to Sign: Staff Name/Date: _____