

Urology Associates, Ltd.
Health Insurance Portability and Accountability Act (HIPAA)
Consent to Use Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow Urology Associates, Ltd. to use or disclose my protected health information for treatment, payment and health care operations.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Urology Associates, Ltd.

I consent to allow Urology Associates, Ltd. to disclose my protected health Information for treatment activities of another health care provider.

I consent to allow Urology Associates, Ltd. to disclose my protected health information to any Urology Associates, Ltd. Facility or Provider or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Urology Associates, Ltd. to disclose protected health information to another Urology Associates, Ltd. Facility or Provider for health care operations activities, provided that Urology Associates, Ltd. and the other Urology Associates, Ltd. has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

(Please Print Patient Name) (Signature of Person Authorizing Consent)

Relationship to patient Date

I hereby acknowledge that I have been presented with a copy of Urology Associates, Ltd. Notice of Privacy Practices.

Signature of Person Authorizing Consent Date

At times patients may wish to have information regarding their medical condition(s), lab reports, medications, Appointment times, etc., discussed verbally with other individuals such as a spouse, other family member, friend, Or caregiver in the office or by telephone. If this applies to you, please indicate below any person whom you Authorize us to verbally release information regarding your care at Urology Associates, Ltd.
If this does not apply, initial here _____

Name _____ Relationship _____ Phone _____

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