ADVANCED UROLOGY INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ADVANCED UROLOGY INSTITUTE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT §164.510 §164.514

USE AND DISCLOSURE REQUIRING THE OPPORTUNITY TO AGREE OR OBJECT

Patient Name: _____ ID Number:_____

SECTION A: FACILITY DIRECTORIES

Medical facilities where I may be a patient create and maintain facility directories for the purpose of identifying and locating patients within that facility. I understand that I have the right to agree, object or restrict any or all of the items listed below from being added to that directory.

I understand that I have the right to agree, object or restrict release of the information to the following entities:

____ FAMILY MEMBERS (ALL OR INDIVIDUAL) ____AGREE ____OBJECT ____RESTRICT

____ OTHER FRIENDS, ACQUAINTANCES, ETC. ____AGREE ____OBJECT ____RESTRICT

(LIST OF INDIVIDUALS)

_____ _____ _____

_____ _____ _____

This opportunity is authorized for the following facility(ies):

_____

_____

_____

SECTION B: EMERGENCY CIRCUMSTANCES

In the event of an emergency situation, in case of disaster or in an attempt to identify or locate relatives, care givers or others involved in my well-being, whereby I am unable to communicate these conditions,

____ My provider may provide the information.
____ My provider may not provide the information.
____ My provider may use his/her best professional judgment on my behalf.

I understand that I have the right to alter or terminate this agreement at any time. I understand that this authorization is voluntary.

_____

Signature of patient or patient's representative **Date**

(Form must be completed before signing.) Printed name of patient's representative:_____

I want to terminate my agreement beginning on_____, 200__.

_____

Signature of patient or patient's representative **Date**

Date: _____

Advanced Urology Institute, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Advanced Urology Institute, LLC is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please mark each area of information that may be given to the person/entity listed on the left in the same section.
o Answering Machine	o Messages regarding appointments, lab tests/ x-rays or procedures o Any other information regarding treatment o Any information regarding Medications
o Spouse (Provide Name and DOB) _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Parents/Children (Provide Name and DOB) _____ _____ _____ _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Other (Provide Name and DOB) _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. _____

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Institute, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

_____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

In compliance with HIPPA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Institute, LLC. I understand a copy of this policy is available for me to take home for my records.

_____ _____

Signature of Patient or Personal Representative Date