LOWCOUNTRY
UROLOGY CLINICS
www.lowcountryurology.com

Receipt of Notice of Privacy Practices
Written Acknowledgement/Authorization

HIPAA Notice of Privacy Practices Acknowledgement

I have received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment and normal healthcare operations of the Practice. 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 healthcare 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.

__________Initials

Authorization to Release and/or Obtain Medical Records

I hereby authorize all physicians participating in my health care, and Lowcountry Urology Clinics, PAs' physicians, the release, use, and disclosure of my entire medical record by mail, phone, fax, and to carry out my treatment, payment, and healthcare operations.

______________________________Signature Required

Authorized Methods of Communication (check all that apply)

1. Okay to leave call back phone number only:

   __Home __Cell __Work

2. Okay to leave detailed message on answering machine/voice mail:

   __Home __Cell __Work

3. Okay to discuss my healthcare treatment with:

   ___Spouse

   ___Family Member__________________

   __Friend______________________

   __Other______________________

I understand that the authorization for release of information will be valid for one year from the date of this signature and can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained as necessary.

______________________ Date

______________________ Patient Name (Please Print)

______________________ Date of Birth

______________________ Signature of Patient or Personal Representative