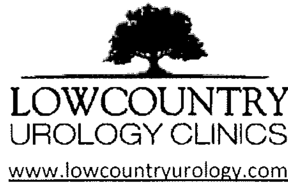

www.lowcountryurology.com

Receipt of Notice of Privacy Practices
Written Acknowledgement/Authorization

HIPAA Notices of Privacy Practices Acknowledgement
I have received, read, and understand the 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.

Initial here: ______________

Authorization to Release and/or Obtain Medical Records
I hereby authorize all physicians participating in my healthcare and Lowcountry Urology Clinics, PA 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:

1. Okay to leave a detailed message on answering machine/voicemail? Yes _________ No _________
2. Preferred phone number (please check one): Home ________ Cell ________ Work ________
3. Please list anyone authorized to access your medical records, treatment details, and/or appointment info:

Name	Relationship	Phone

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.

_______________________________________ Signature of Patient or Personal Representative

_______________________ Date

_______________________________________ Patient Name (Please Print)

_______________________ Date of Birth