Southwest Premier Urology Authorization for Disclosure of Health Information

Patient Name:_____ DOB:_____

Patient Address:_____ City:_____ State:_____ Zip Code:_____

I authorize Southwest Premier Urology to use or disclosure of the above named individual's health information as described below:

The type of information and dates (if listed) to be disclosed (make all that apply) is as follows:

__Complete Health Record __Physical Exam __Immunization Record __Lab Results __X-ray Reports

__Consultation Reports __Other_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to the office manager. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign the authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provider in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information I may contact the Privacy Officer for Southwest Premier Urology.

_____ _____

Patient or Legal Representative Signature Date

_____

Printed Name of Legal Representative

_____ _____

Witness Signature Date

Confidential Communication Request Form

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call and would like to be able to leave a detailed telephone message (medical results) when possible. In order to protect your privacy we need your written permission to leave detailed messages for you. It should be noted that our current Notice of Privacy Practices does allow us to call you with a courtesy reminder regarding any upcoming appointments. Please read the following choices and indicate which methods of communication you consent to.

Patient Name:_____ DOB:_____

Please choose one of the following:

I **DO CONSENT** for Southwest Premier Urology providers and staff to leave detailed messages per my instructions below. I _____ give Southwest Premier Urology providers and staff permission to leave telephone messages regarding my medical care using the following options: Please complete each section that is applicable.

Please Initial:

___ Voice Mail Phone Number:_____

___ Spouse Name and Phone Number:_____

___ Other Person(s) Name and Phone Number:_____
_____

Consent Signature:_____ Date:_____

I DO NOT CONSENT for Southwest Premier Urology to leave detailed messages. I understand that I will have to wait until I can speak with a staff member to receive any information regarding my health care.

Do Not Consent Signature:_____ Date:_____

Revocation of Prior Consent: I wish to rescind the above authorization(s).

Revocation Signature:_____ Date:_____

If not signed by the patient, please print your name and indicate your relationship to the patient:
Name:_____ Relationship:_____

I understand that if **I choose to bring a family member or friend** with me to my appointment, my personal information will be discussed in front of this person. Furthermore, I understand that if I ask questions about my healthcare outside of an exam room, it may be possible for others to hear my personal information. I understand it is best to discuss my medical care privately in an exam room.

Patient Signature:_____ Date:_____