

Urology Associates of North Texas

HIPAA Disclosure

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at Urology Associates of North Texas, L.L.P. (UANT), or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by UANT to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Conduct normal healthcare operations such as quality assessments and physician certifications, (d) Notification of educational events specific to my medical condition through UANT or networking organizations, (e) Consent to property transfer of specimen (tissue obtained during a medical test) to UANT, and (f) Any such other purposes permitted under HIPAA.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that UANT has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at P.O. Box 120549, Arlington TX 76012.

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. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I prefer to be contacted in the following manner:

Phone#: () _____

Phone#: () _____

- Leave message with detailed information.
- Leave message with contact number only.
- Do Not leave message.

- Leave message with detailed information.
- Leave message with contact number only.
- Do Not leave message.

I prefer to receive reminders regarding upcoming appointments in the following manner:

- Leave message.
- Decline/Do Not Call.

I prefer to receive a summary of my office visit in the following manner (available at a later date):

- Printed.
- Decline (prefer not to receive at the completion of my office visit).

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This authorization affects your rights regarding the privacy of your personal healthcare information.
Please read it carefully before signing.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be affected by my signing or not signing this release.

PLEASE SELECT OPTION A (or) B:

A. I hereby authorize Urology Associates of North Texas, L.L.P. (“UANT”) to use and/or disclose the protected health information described below for the purpose(s) of treatment and care. **(Select one of the options below)**

_____ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

_____ I hereby authorize the release of my complete health record with EXCEPTION of the following information:
 Mental health records
 Communicable diseases (including HIV and AIDS)
 Alcohol/drug abuse treatment
 Other (please specify): _____

Complete this Section if you checked either of the options above:

I authorize UANT or its Business Associates to release information to the following family members or friends for the period of health care from **(PLEASE CHECK ONE)**

All past, present and future periods **OR** _____ to _____

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

B. Do not discuss/release my medical records or private information to anyone (including family members) or any entity. This option is not available for our minor patients; we must have written documentation indicating the adult caregiver(s) with whom we may discuss the child’s care.

This authorization shall be in force and effect until _____ (date or event) or until properly revoked by me at which time this authorization expires. To revoke my authorization, I must submit a Revocation of Authorization Notice to Urology Associates of North Texas at P.O. Box 120549, Arlington, TX 76012, Attn: Medical Records Manager.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law. UANT and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA, federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient

You have the right to receive a copy of this HIPAA privacy authorization