

Southwest Urology, Inc.
Consent for purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Southwest Urology, Inc for the purpose of diagnosing, or providing treatment of me, obtaining payment for my health care bills or to conduct health care operations of Southwest Urology, Inc. To the extent available, Southwest Urology, Inc may obtain prescription information and send prescription information electronically to assist in my medical treatment.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. Southwest Urology, Inc. is not required to agree to the restrictions that I may request. However, if Southwest Urology, Inc. agrees to a restriction that I request, the restriction is binding on Southwest Urology, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Southwest Urology, Inc. has taken action in reliance to this consent. This authorization will be in effect until it is revoked or terminated by the patient or patient's representative. You may revoke or terminate this authorization by submitting a written revocation to Southwest Urology, Inc. to the attention of the Privacy Officer or by calling 440-845-0987.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Southwest Urology, Inc. Privacy Notice prior to signing this document. The Privacy Notice describes the types of uses and disclosures of my protected health information.

Southwest Urology, Inc. reserves the right to change the privacy practices that are described in the Privacy Notice. I may obtain a revised privacy notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With this consent, Southwest Urology, Inc. may call my home or alternative location and leave a message on voice mail or with an individual in reference to any items that assist the practice in fulfilling treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to your care, including test results.

With this consent, Southwest Urology, Inc. may mail to my home or alternative location any items that assist the practice in fulfilling treatment, payment and healthcare operations. I have received the NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION and understand that my protected health information may be used by the Practice as described in the notice.

Name of Patient (Print) _____

Signature (Patient or Representative) _____

Date Signed _____ Representative's relationship to patient _____