Urology Associates *of* SENC, PA

HIPPA FORM

Patient's Name: _____

Patient's Date of Birth: _____ Chart#: _____

The Department of Health and Human Services has established a "Privacy Rule" to help insure that Personal Healthcare Information is protected for privacy. In order to insure your privacy, we are requesting that you provide us with the names of people who may call on your behalf.

Please understand that we are unable to release any information to any person who is not listed below. Again, this is for your protection, to insure information is protected for privacy.

I hereby authorize the following people to receive information, make appointments, call regarding medications, receive laboratory and/or x-ray results, etc.

Names	Phone Number
_____	_____
_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipts of the Notice of Privacy Practices given to me by Urology Associates.

Signature: _____ Date: _____

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FOR OFFICE USE ONLY:

If not signed, reason why acknowledgement was not obtained: _____

Employee Signature: _____ Date: _____