

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

I acknowledge that I have received and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction.

Also, I consent to the use or disclosure of my protected health information by Urology Center of Florida, and all of its departments, operations, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its healthcare operations that specifically includes all satellite locations, billing and administration, laboratory and diagnostic center, Florida Foundation for Healthcare Research, and Specialty Surgery of Ocala.

**X**

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Signature)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Printed Name)

\_\_\_\_\_  
Relationship If Other Than Patient

### AUTHORIZATION

In compliance with HIPAA's Privacy Rule, it is the policy of this office to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in force until revoked in writing by the Patient. Please list below the individuals you wish to have access to your protected health information.

|   |       |                         |
|---|-------|-------------------------|
| 1 | _____ | _____                   |
|   | Name  | Relationship to Patient |
| 2 | _____ | _____                   |
|   | Name  | Relationship to Patient |
| 3 | _____ | _____                   |
|   | Name  | Relationship to Patient |
| 4 | _____ | _____                   |
|   | Name  | Relationship to Patient |
| 5 | _____ | _____                   |
|   | Name  | Relationship to Patient |

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