ACADEMIC UROLOGY & UROGYNECOLOGY OF ARIZONA

HIPAA CONSENT

(Authorization to Disclose Health Information to Family Members and Friends)

PATIENT NAME _____ DATE OF BIRTH _____/_____/_____

I hereby authorize Academic Urology & Urogynecology of Arizona to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)	
Name of Family Member or Friend	Relationship	Medical	Billing
1.			
2.			
3.			
4.			
5.			
6.			

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

[Check One]

I Do _____ I Do NOT _____ GIVE PERMISSION to Academic Urology & Urogynecology of Arizona to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments [time, date, location] to be left on an answering machine or with family members.

_____ _____

Signature of Patient or Personal Representative (i.e. Guardian) Relationship of Personal Representative to Patient

Date of Authorization _____