STATEMENT OF PRIVACY POLICY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

I Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
I Obtain payment from third-party payers.

I Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Tennessee Urology Associates (TUA) of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that TUA restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand TUA is not required to agree to my requested restrictions, but if TUA does agree then the organization is bound to abide by such restrictions.

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

Release of information contacts:

First Individual: ____

Relationship: ______________________________ Phone Number:______________________

Second Individual: ____

Relationship: ______________________________ Phone Number:______________________

Third Individual: ____

Relationship: ______________________________ Phone Number:______________________

I accept: ____
(Signature)

____
(Date)