



HIPAA ACKNOWLEDGMENT AND CONSENT

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

I understand that Willamette Urology, P.C. will use and disclose health information about me. I understand that my health information may include information both created and received by the practice. It may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand that I have the right to receive and review a written description of how Willamette Urology, PC will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, physicians and other personnel of Willamette Urology, PC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of Willamette Urology, P.C. **Notice of Privacy Practices is available in the lobby and on our web site at www.WillametteUrology.com**

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Willamette Urology, P.C. is not required by law to agree to such requests.

I understand Willamette Urology, P.C. is restricted in discussing my health information with family members or friends without written permission. I hereby authorize Willamette Urology, PC to release medical information regarding myself to the person(s) listed below. I understand this information may include diagnosis, treatment and lab or x-ray results.

CONSENT TO RELEASE INFORMATION – PERSON(S) AUTHORIZED TO RECEIVE INFORMATION:

Name Relationship

Name Relationship

I agree that I have reviewed and understand the information above and that I am free to take a copy of the Notice of Privacy Practices available at the reception counters and online at www.WillametteUrology.com

PATIENT SIGNATURE

DATE