

# Central Ohio Urology Group, Inc.

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620 Morrison Road, Gahanna, OH 43230 \* (614) 944-4760 \* FAX (614) 944-4761

## **Patient Acknowledgement Form Notice of Privacy Practices**

I have received a copy of the Notice of Privacy Practices from Central Ohio Urology Group, Inc.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Declined the Notice of Privacy Practices from Central Ohio Urology Group, Inc.

Staff's Signature: \_\_\_\_\_

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**Please Check all that Apply:**

1) Central Ohio Urology Group may disclose my information to:

- \_\_\_ Any Health Care Provider or Facility
- \_\_\_ Spouse (Name) \_\_\_\_\_
- \_\_\_ Children (List names) \_\_\_\_\_
- \_\_\_ Other (List name) \_\_\_\_\_

2) The physician/practice may use or disclose the following protected health information:

- \_\_\_ All test results
- \_\_\_ The entire medical chart
- \_\_\_ Chart notes only

3) The physician/practice should **not** disclose the following information:

\_\_\_\_\_ (indicate reason)

4) The physician/practice may leave a detailed message at:

- \_\_\_ Home
- \_\_\_ Cell
- \_\_\_ Work

I understand that it is my responsibility to notify Central Ohio Urology Group, Inc. in writing if I want to make any changes to the above.

Patient's Signature: \_\_\_\_\_