central ohio UROLOGY group

Patient HIPAA and Notice of Privacy

PATIENT INFORMATION		
Last Name:	First Name:	M.I.:
DOB: / /		

NOTICE OF PRIVACY PRACTICES

☐ I have received a copy of the Notice of Privacy

Patient / Guardian Signature _____ Date _____

HIPAA AND MEDICAL RECORDS CONSENT

I hereby give permission to Central Ohio Urology Group to disclose my name, contact information, social security number, progress notes, laboratory test results, radiology reports, Individually Identifiable Health Information and Protected Health Information (PHI) to other physicians, health care practitioners, providers and laboratories that work with your physicians with respect to my treatment, and to health plans with respect to payment for my treatment.

I give permission to Central Ohio Urology Group to use my PHI for its Health Care Operations. I also give permission to release my medical and billing records to myself or to my guardian.

Patient / Guardian Signature _____ Date _____

Is there something you do not want us to disclose? _____

Is it okay to leave a Voicemail Message about your care? ☐Yes ☐No

Cell:	Home:	Work:

Please list any additional people that we are allowed to discuss your medical information with:

☐	Spouse	Name:	Phone:
☐	Child	Name:	Phone:
☐	Other	Name:	Phone:
☐	Other	Name:	Phone: