

COLORADO UROLOGY CENTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the Colorado Urology Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The Colorado Urology Center’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Colorado Urology Center reserves the right to revise its Notice of Privacy Practices at anytime. A reviewed Notice of Privacy Practices may be obtained by forwarding a written request to the Colorado Urology Center 400 State Street, Fort Morgan Colorado 80701.

With this consent, the Colorado Urology Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Colorado Urology Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the Colorado Urology Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Colorado Urology Center restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the Colorado Urology Center’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Colorado Urology Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient’s Name

Date

Print Name of Patient or Legal Guardian