THE UROLOGY CLINIC
GEORGIA LITHOTRIPSY & LASER CENTER

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

The Urology Clinic Georgia Lithotripsy & Laser Ctr 120 Trinity Place Athens, GA 30607	Patient Name: Address:

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for The Urology Clinic and Doctor _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____Relationship to Patient :_____Phone #_____

Name: _____Relationship to Patient: _____Phone #_____

Name: _____Relationship to Patient : _____ Phone #_____

Conditions for Disclosure (Check the item(s) that apply):

☐ The practice may disclose my personal health information to the individual(s) above **only** in my presence.

☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.

☐ Other Conditions of Disclosure: _____

_____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____ Title/Position:_Receptionist_____

Print Name of Witness: _____

Date: _____

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The Physicians and Staff of Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of The Urology Clinic/Georgia Lithotripsy & Laser Center's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____

(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

_____