

CENTER FOR UROLOGICAL SERVICES, PC

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Center For Urological Services, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Center For Urological Services, PC'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. Center For Urological Services, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Center For Urological Services, PC Privacy Officer at **4545 E Chandler Blvd #300 Phoenix, AZ 85048**.

With this consent, Center For Urological Services, PC may call my home or other alternative location and leave a message on voice mail or with the answering person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance items. Any calls pertaining to my clinical care, including laboratory results among others, will only be released to those whom I have expressly given my written permission as follows:

Name	Relationship	Phone # (including area code)

With this consent, Center For Urological Services, PC 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 as long as they are marked Personal and Confidential.

With this consent, Center For Urological Services, PC 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 Center For Urological Services, PC 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 Center For Urological Services, PC'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, Center For Urological Services, PC may decline to provide treatment to me.

Best phone number to reach me Monday though Friday 9:00am to 5:00pm:
() _____ extension _____

Signature of Patient or Legal Guardian

Print Patient Name

Print Name of Legal Guardian if applicable

Date