

UROLOGY ASSOCIATES OF KINGSPORT, P.C.

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ACKNOWLEDGEMENT OF NOTICE ¹

Consent to the USE and DISCLOSURE of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis' and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I acknowledge receipt of Urology Associates of Kingsport, P. C. Notice of Privacy Practices which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize Urology Associates of Kingsport, P. C. to leave messages regarding appointment information on my answering machine, with a family member, or individual allowed to receive information on my behalf in the event that I cannot be reached by phone.

Yes _____
(Initial)

No _____
(Initial)

Signature of Patient or Legal Representative

Date

Patient's Name (Please Print)