

**Clinic of Urology Patient Consent for Use and  
Disclosure of Confidential Health Information**

45 CFR § 164.506

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birthdate : \_\_\_ \_\_\_ / \_\_\_\_\_

By signing this form you are consenting to Clinic of Urology use and disclosure of your protected health information to carry out treatment, payment or health care operations. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

If you do not agree to sign this form, the Clinic of Urology may refuse to treat you.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of the Notice. Any new notice provisions will be effective for all protected health information that we maintain.

You have the right to request that the Clinic of Urology restrict how we use and disclose your protected health information. We are not required to agree to such a restriction, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclosure to the extent we document such in writing and notify you of the same.

You have the right to revoke this consent in writing at any time except to the extent that the Clinic of Urology has acted in reliance on it.

I understand and agree to the foregoing:

\_\_\_\_\_  
Signature of patient  
Or personal representative of patient

\_\_\_\_\_  
Date

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If personal representative, indicate  
Relationship to patient.

**YOU ARE ENTITLED TO A COPY OF THIS SIGNED CONSENT FORM UPON  
REQUEST.**