

Consent to Use or Disclose Medical Information

I **authorize** Iseri and Associates Urology to **use and disclose** the health and medical information of _____ for the purposes of **treatment, payment, and health care operations.***
(name of patient)

***Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).

***Health Care Operations** (includes the necessary administrative and business functions of this office).

You may review Iseri and Associates Urology **"Notice of Privacy Practices"** for additional information about the uses and disclosures of information described in this consent prior to signing this CONSENT. Please verify that you have received/read a copy of our **"Notice"** by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in the waiting room of our office indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for this office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so in writing except to the extent that Iseri and Associates Urology has already used or disclosed the information in reliance on this CONSENT.

(Date) _____ (Signature of patient) (or)

(Date) _____ (Signature of person authorized by law)