UCA | Urology Centers Of Alabama

HIPAA Contacts

By signing below, you hereby consent for Urology Centers of Alabama, P.C. (UCA) to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for UCA before signing this consent. The terms of the notice may change from time to time, but you can always request a revised copy by asking the Privacy Officer.

You have the right to request that UCA restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. UCA is not required to agree to requested restrictions, however, if UCA agrees to your requested restrictions, the restriction is binding.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless UCA has taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Release of Protected Health Information

Would you like to allow UCA and its staff to discuss your account of medical conditions which may include symptoms, treatments, tests, medicine, emergency situations, or other protected health information to a person of your choosing for the purpose of facilitating your treatment and payment of your account?

☐ **Yes** ☐ **No**

Patient signature: _____ Date: _____

Please enter the full name of the person you would like to allow Urology Centers of Alabama to release protected health information to:

_____

Please enter their relationship to the patient: _____

Please enter their phone number: _____

Please enter the full name of a second person you would like to allow Urology Centers of Alabama to release protected health information to:

_____

Please enter their relationship to the patient: _____

Please enter their phone number: _____