NAPA VALLEY UROLOGY ASSOCIATES

PROVIDING CARE SINCE 1952

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Napa Valley Urology Associates' (NVUA) Notice of Privacy Practices provides information about how we may use and disclose protected health information may be used. You have a right to review this Notice before signing the consent. The terms of the Notice may change, and if this should occur, you may receive a revised copy by contacting NVUA's Office Manager.

You have the right to restrict how protected health information about you is used or disclosed for *treatment, payment, or healthcare operations*. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for *treatment, payment, or healthcare operations.* You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent.

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or health care operations.
2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice upon request.
3) The practice reserves the right to change the notice of privacy practices.
4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The Consent is signed by:

_____ _____

Patient's Printed Name Date

_____ _____

Signature of Patient/Representative Representative/Guardian/Parent **Printed** Name

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