potomac UROLOGY

Alexandria Location
4660 Kenmore Ave, Suite 1120
Alexandria, VA 22304

tel: 703-680-2111
fax: 703-878-3939

Woodbridge Location
2296 Opitz Blvd, Suite 350
Woodbridge, VA 22191

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

The attached notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

- By my signature below, I acknowledge that I have received the Notice of Health Information Practices of **POTOMAC UROLOGY CENTER**.
- I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided.
- I understand that I have the right to request restrictions as to how my health information may be used or disclosed 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.

COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Potomac Urology Center will not release confidential health information (in person, by telephone, email, or fax) to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).

If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

- I authorize the physicians and staff of Potomac Urology Center to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Potomac Urology Center if this authorization information changes.

It is okay to leave confidential medical information for me on my: (list numbers)
□ Home telephone/answering machine _____
□ Work telephone _____
□ Mobile telephone _____

It is okay to give confidential medical information to my: (list names)
□ Spouse: _____
□ Parent(s): _____
□ Son/Daughter: _____
□ Brother/Sister: _____
□ Other: _____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

_____ _____ _____
Patient Signature /Guardian Signature Printed Name Date