

**What is this?**

Federal law requires you to sign this form to receive care here. The form outlines how your privacy is protected in this office.

**Beaver Valley Urology, LTD**

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Beaver Valley Urology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

I have the right to review the Notice of Privacy Practices prior to signing this consent. If you choose to review with Notice of Privacy Practices, it must be read, understood and signed prior to your visit with us. Beaver Valley Urology reserves the right to revise its Notice of Privacy Practices at anytime. A revised copy can be provided upon request.

With my consent, Beaver Valley Urology, LTD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, Beaver Valley Urology, LTD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Beaver Valley Urology restrict how it uses or discloses by PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Beaver Valley Urology's uses and disclosure of my PHI to carry out TPO.

I may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Beaver Valley Urology, LTD may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Legal Name of Patient or Legal Guardian

**Beaver Valley Urology, LTD**  
**Patient Privacy Consent to Release Information**

Please provide us with a list of names of people you authorize us to release information to:

i.e., spouse, child, siblings, parents, clergy, friends or other family members

1.

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2.

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3.

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Signature of Patient or Legal Guardian

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Date

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Printed Name of Patient or Legal Guardian