New Jersey Urology — Excellence In Care

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices which provides information about how we may use and disclose Protected Health Information (PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

☐   I acknowledge that I have received a copy of the New Jersey Urology Notice of Privacy Practices.

(For Office Use Only)

☐   We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the patient, but it could not be obtained because:

_____

_____

Employee Signature/Date**:** _____

Consent for Release of PHI to Individuals

We cannot discuss your PHI with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below, name(s) of the individual(s) (family, friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing or 1 year from the date of your signature below, whichever comes first. For patients who are considered a minor, this form expires when the patient reaches 18 years of age, or a legal guardian informs us in writing that the consent has been revoked.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____

Name of Patient (print) _____ Date of Birth _____

Signature of Patient _____ Date _____

Signature of Patient Representative _____ Date _____
(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____ Print Name _____

Revised January 6, 2020