UrologyAustin

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Greenwell, David P MD
Horan, John J MD FACS
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Maloney, Shaun A MD
McClelland, Michael L Jr MD
Northway, Robert O III MD
Phillips, David L MD
Pickett, Steven MD PhD
Putzi, Mathew J MD
Ruff, Peter A MD
Singh, Herb MD
Williamson, John C MD

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION & ASSIGNMENT OF BENEFITS

_____ (Initial) I have read and acknowledge Urology Austin's Notice of Privacy Practices. Urology Austin complies with all regulatory guidelines with regard to safeguarding your protected health information (PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physician, but not with my spouse. These guidelines and our policies are published in this Notice. A copy for my records will be provided at my request.

_____ (Initial) I authorize my primary care physician, referring physician and other care providers to furnish any and all information concerning my present illness or injury to Urology Austin.

_____ (Initial) I authorize Urology Austin to leave information and appointment reminders at the following:

☐ Home Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Email Address: _____

Please list any authorized entities with whom we can share your PHI: ☐ None

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance plan benefits directly to Urology Austin for services provided. I understand that I am financially responsible to Urology Austin for all cost-share expenses (co-pay, co-insurance and deductible), as well as any services not covered by my insurance plan.

_____ Patient Name

_____ Patient DOB

_____ Patient Signature

_____ Date Signed

_____ Guarantor Signature (if different than patient)

_____ Date Signed