



**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 about 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 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: \_\_\_\_\_  
 Consent to text communications (beyond appointment reminders)

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