UrologyAustin
An affiliate of Urology America
What World-Class Urology Looks Like

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION & ASSIGNMENT OF BENEFITS

Initial:

_____ I have read and acknowledge Urology Austin PLLC's ("Urology Austin") Notice of Privacy Practices ("Privacy Notice"). 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 Privacy Notice. A copy for my records will be provided at my request.

_____ 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.

_____ I consent that Urology Austin can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of on-line communications, provided that these communications comply with privacy regulations.

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, PLLC 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 date of birth

_____ _____
Patient Signature Date signed

_____
Parent or legal guardian signature
(if different than patient or patient is a minor)