Acknowledgement of Receipt of Privacy Practices

Patient Name ____________________________

Date of Birth ____________________________

I have received or been offered Advanced Urology Centers of New York's Notice of Privacy Practices written in plain language, and have been given the opportunity to read and ask questions about the Notice. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

NOTE: Messages may be left for you on your answering machine or with a person who may answer your home / cell / work phone in regard to office questions, appointments and pre-certification authorization numbers.

I, ____________________________________(print Patient name), give permission to the office and affiliates of Advanced Urology Centers of New York, to leave a message at the following phone numbers provided.

Please provide at least one phone number:

- ☐ yes ☐ no Home # ____________________________
- ☐ yes ☐ no Answering Machine ____________________________
- ☐ yes ☐ no Work # ____________________________
- ☐ yes ☐ no Voice Mail # ____________________________
- ☐ yes ☐ no Cell # ____________________________

The office and affiliates of Advanced Urology Centers of New York may release any of my medical information to the following people (i.e. spouse, children, siblings, etc.):

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________

Signature of Patient or Authorized Signature Date

(if over 18 years of age)

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Printed name of Patient or Authorized Signature

(if patient is under 18 years of age)

FOR FACILITY USE ONLY (For documentation of refusal to sign)

Advanced Urology Centers of New York made the following good faith efforts to obtain the above- referenced patient's written acknowledgement of receipt of the Notice of Privacy Practices:

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Signature of Staff Member ____________________________ Date ______________