

Asheville Urological Associates, Inc.

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This notice of Privacy Practices is effective on the date you sign a statement stating you have read or been offered the opportunity to read this statement. All standard compliances to HIPAA will be followed from April 15, 2003.

NOTICE OF PRIVACY PRACTICES OF ASHEVILLE UROLOGICAL ASSOCIATES, INC AND AFFILIATED PHYSICIANS

I, _____, have been offered the opportunity
(Print Name)

and/or have read the Notice of Privacy Practices of Asheville Urological Associates, Inc., and the affiliated physicians.

Signature

Date

In order to comply with the new HIPAA regulations and protect your patient confidentiality, we need to know if there is a phone (answering machine or answering service) for you where we can leave results of your laboratory or other tests. Also, I hereby authorize one or all of the designated parties below to request and receive the release of any protected information regarding my condition, treatment, payment, account or administrative operations related to treatment and payment. I understand the identity of designated parties may be verified before the release of any information.

I give Asheville Urological Associates employees permission to leave confidential health care information for me at the following number(s). _____
(write "none" in none).

AUTHORIZED DESIGNEES:

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

I understand this number and these names will be used until I notify Asheville Urological Associates, Inc. that it should no longer be used.

Signature

Date