Patient Name (please print): __________________________________________________

I, ______________________________________, acknowledge that I have read and received a copy of the Privacy Statement from Michigan Institute of Urology.

Patient Signature: ___________________________ Date: ___________________

Personal Representative Signature: ___________________________ Relationship to Patient: ___________________________
(If patient is unable to sign)

I do not want “appointment reminders” left on my:

Answering machine/voice mail

E-mail

Patient Signature: ___________________________ Date: ___________________

For Office Use Only:

Patient refused to sign
Patient unable to sign due to communication/language barrier
Patient unable to sign due to emergency situation
Other (Please explain):

__________________________________________________             ________________

Office Representative Signature: ___________________________ Date: ___________________
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Information about the Patient:

Patient Name: ___________________________ DOB: ___/___/_____
Address: _______________________________ Phone: ________________

Information About the Person Authorizing the Disclosure of PHI, if Other Than the Patient Listed Above:

Name: _________________________________ Relationship to Patient: ___________________________
Address: _______________________________ Phone: ________________

Authorization:

I, ___________________________ (Name), as the Patient or Patient’s authorized representative identified above, hereby authorize Michigan Institute of Urology, P.C. (MIU) to disclose to the following person or entity the Patient’s protected health information (PHI), as defined by HIPAA:

Recipient’s Name: ___________________________ Phone: ________________
Address: _________________________________

Complete Recipient’s information below to allow MIU to confirm Recipient’s identity when he/she contacts us:

Recipient’s Last 4 Digits Social Security #: ___________________________
AND/OR
Recipient’s ‘s Mother’s Maiden Name: ____________________________

Please limit the disclosures of PHI to the Recipient to the following (complete if applicable):

Description: ____________________________

(Note: In lieu of describing the limitations, you may say: “MIU may disclose all of Patient’s PHI to the Recipient”)

I understand that (i) authorizing the disclosure of PHI to the Recipient is voluntary, (ii) this Authorization covers multiple disclosures and/or requests for PHI and I authorize MIU to make such disclosures and to respond to such requests, (iii) I may refuse to authorize disclosure of PHI, and MIU may not condition, withhold or refuse treatment on whether I sign this authorization, (iv) I may revoke this Authorization at any time by completing a revocation form (available at the front desk) and returning it to MIU’s HIPAA Privacy Official at 20952 12 Mile Road, Suite 200, St. Clair Shores, MI 48081, (v) any disclosure of PHI carries with it the potential for an unauthorized re-disclosure by the Recipient and the information may not be protected by federal or state privacy rules, and (vi) MIU must provide me a copy of this signed Authorization.

If not previously revoked, this authorization shall expire on the date which is one (1) year from the date of the Patient’s last visit to MIU. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid.

Signature of Patient / Authorized Representative ___________________________ Date ____________

Note: If we reasonably believe that a Patient, including an unemancipated minor, has been or may be subjected to domestic violence, abuse or neglect by the personal representative, or that treating a person as Patient’s personal representative could endanger the Patient, we may choose not to treat that person as the Patient’s personal representative, if in the exercise of professional judgment, doing so would not be in the best interests of the Patient.