

Southwest Urology Associates
Authorization and Acknowledgement Form

Patient's Name: _____

Date of Birth: _____

(Please Print)

Assignment of Benefits

I authorize and request that payment of authorized insurance benefits, including Medicare benefits, (if applicable) be made directly to Southwest Urology Associates, or any of their physicians for services provided during the course of my treatment.

Patient's or Authorized Representative's Signature

Date

Authorization to Release Information - Insurance

I authorize Southwest Urology Associates to disclose any medical or any other information necessary to my insurance company(s). I understand that the purpose of this disclosure is to facilitate payment of insurance benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. The original authorization will be kept on file with Southwest Urology Associates.

Patient's or Authorized Representative's Signature

Date

HIPAA - Acknowledgement of Receipt – Notice of Privacy Practices

I understand that my medical records maintained by Southwest Urology Associates contain protected health information that is private and confidential. I am aware that Southwest Urology Associates can and will use and disclose my protected health information within its organization, to carry out my treatment, to obtain payment and to carry out healthcare operations.

I have been provided with a copy and/or have downloaded a copy of Southwest Urology Associates Notice of Privacy Practices, which provides a more complete description of how protected health information may be used and disclosed and what my privacy rights are as a patient. I understand that I have a right to review this notice prior to signing this acknowledgement and if at any time I have any questions I may contact Southwest Urology Associates' Privacy Officer.

Patient's or Authorized Representative's Signature

Date

HIPAA - Authorization to Release Protected Health Information

I authorize Southwest Urology Associates to disclose my protected health information including, but not limited to, treatment, billing/financial, and appointment information to the following individuals also involved in my care:

Name of Individual

Relationship to Patient

**The following authorizations will be considered effective and valid until withdrawn in writing by me, the undersigned.

Patient's or Authorized Representative's Signature

Date