PHI CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information (PHI) by Fayetteville Urology Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Fayetteville Urology Associates. I understand that diagnosis or treatment of me by health care providers of Fayetteville Urology Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations of the practice. Fayetteville Urology Associates is not required to agree to the restrictions that I may request; however, if Fayetteville Urology Associates agrees to the restriction that I request, the restriction is binding on Fayetteville Urology Associates, its physicians and staff.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I have been offered a copy of Fayetteville Urology Associates' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of health care operations of Fayetteville Urology Associates. A copy of the Notice of Privacy Practices for Fayetteville Urology Associates is located at the reception desk. This Notice of Privacy Practices also describes my rights and Fayetteville Urology Associates' duties with respect to my protected health information.

Fayetteville Urology Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my appointment.

I hereby authorize Fayetteville Urology Associates, its physicians and employees, to release any information acquired in the course of my examination or treatment to my insurance carrier, third party payers, or others involved in the processing and collection of my insurance claims. I understand it is my responsibility to advise Fayetteville Urology Associates when my insurance carrier changes. I further authorized Fayetteville Urology Associates, its physicians and employees, to release personal and health information as necessary to my referring physicians and/or family physicians and their offices, and to medical offices and facilities as necessary in the scheduling of studies or procedures as ordered by Fayetteville Urology Associates' physicians. I understand it is my responsibility to advise Fayetteville Urology Associates if my referring or family physician changes to assure records are forwarded to the appropriate doctor. I understand and authorize this information to be forwarded by phone, fax, mail, or electronic transmission.

I understand I can revoke this authorization at any time, except to the extent that Fayetteville Urology Associates has taken action in reliance on this consent, by providing a written, signed statement for my file.

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Signature of Patient or Legal Representative

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Patient Name (PRINT) Date