

Consent for Use and Disclosure of Protected Health Information

By signing this form, you are granting consent to Children’s Urology of the Carolinas to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change at any time. You may obtain a copy of the revised notice by contacting our office at 704-376-5636.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment and health care operations. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

I have been given the opportunity to read the full Notice of Privacy Practices and asked appropriate questions as necessary. I understand and agree with these Privacy Practice policies.

X _____ Date _____

Print Name of Responsible Party _____

Patient Name _____