



Acknowledgement of Receipt

By signing below, I acknowledge that I have received a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

Print Name of Patient or Patient's Personal Representative

Signature of Patient or Patient's Personal Representative

Description of Personal Representative's Authority

Date

If you have any questions about this notice or would like further information, please contact the Privacy Officer at Garden State Urology, LLC, Jeanmarie Falco.

For office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

Consent to Discuss Health Care

Patient Name: _____

Today's Date: _____

Date of Birth: _____

I authorize _____
to discuss my health care information with the individuals listed below.

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I give permission to leave my health care information at the following telephone number(s).

Home: _____

Cellular: _____

Work: _____

Other: _____

Signature of Patient, Parent or Legal Guardian

Printed Name