

SUBURBAN UROLOGIC ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

This acknowledgment of notice and consent authorizes Suburban Urologic Associates to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. Suburban Urologic Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent. You may, upon request, receive a copy of our Notice of Privacy Practices.

Amendments. We reserve the right to change our Notice of Privacy Practices and make the terms of any change effected for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**Privacy Officer Contact Information.** You may contact our Privacy Officer at the following address:

Privacy Officer, Suburban Urologic Associates, 2790 Mosside Blvd Suite G110, Monroeville, PA 15146

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The doctors and staff of Suburban Urologic Associates are dedicated to protecting the privacy of your medical information (including treatment, payment, and health care operations). Therefore, we **WILL NOT** discuss any of this information with anyone other than yourself There are, however, circumstances where patients may want us to speak with a family member or a friend. If this is your request, please complete the following information;

(Family or Friend) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**If the above information is not completed, we WILL NOT discuss your medical information with anyone other than yourself.**

**Confidential information regarding your care will not be left on answering machines, voicemail, or with someone other than yourself.**

**Acknowledgment and Consent**

**I acknowledge that I have read Suburban Urologic Associates' Notice of Privacy Practices. I understand my rights regarding my protected health information.**

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Signature of Patient (or Guardian)

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Date