BAY AREA UROLOGY ASSOCIATES
H. R. WAGNER, M.D., F.A.C.S.

8 PROFESSIONAL PARK DRIVE
WEBSTER, TEXAS 77598
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FAX (281) 332-6123

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

I understand that under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers, who may be involved in that treatment directly and indirectly
- Obtain payment from third- party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your ***NOTICE OF PRIVACY PRACTICES*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***NOTICE OF PRIVACY PRACTICES*** prior to signing this consent. I understand that BAY AREA UROLOGY has the right to change its ***NOTICE OF PRIVACY PRACTICES*** from time to time and that I may contact BAY AREA UROLOGY at any time at the address above to obtain a current copy of the ***NOTICE OF PRIVACY PRACTICES***.

I understand that I may request in writing that you restrict how my private information is used for disclosure to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I prefer to be contacted in the following manner:

Phone#: ( ) _____

- ☐ Leave message with detailed information.
- ☐ Leave message with contact number only.
- ☐ Do Not leave message.

Phone#: ( ) _____

- ☐ Leave message with detailed information.
- ☐ Leave message with contact number only.
- ☐ Do Not leave message.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

Bay Area Urology was unable to obtain acknowledgment / consent because:

- ☐ Patient Confused / Disoriented ☐ Patient Refused – Reason_____
- ☐ Patient Disability requires additional outside education/interpretation from other than Bay Area Urology Associates
- ☐ Patient received acknowledgement/consent packet, requests to take home, read, sign and return to Bay Area Urology Associates

Revised 2.14.2014