Urology Specialists
of West Florida

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices. I agree that my signature will be valid as long as I am a patient of Urology Specialists of West Florida LLP.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the practice will provide current Notice of Privacy Practices on request.

I authorize USWF LLP to release my PHI to the following individuals or service providers:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature:_____

Date:_____

I was unable to obtain the patient's signature.

Date:_____ Name:_____