NOTICE OF PRIVACY PATIENT ACKNOWLEDGEMENT

Patient Name_____ Date of Birth_____

I understand that, under The Health Insurance Portability Accountability of 1996 and HIPAA Omnibus Final Rule of 2013, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understand The Notice of Privacy Practices. I agree that my signature will be valid as long as I am a patient of Urology Specialist 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 Practice on request.

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

Name_____Relationship_____Telephone_____

Name_____Relationship_____Telephone_____

Name_____ Relationship_____Telephone_____

Name_____ Relationship_____Telephone_____

Patient Signature_____ Date_____

I was unable to obtain the patient's signature.

Date_____ Name_____