Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

HIPAA Authorization

I authorize the use and/or disclosure of my protected health information, as set forth below. I understand that this authorization is voluntary. I understand that, if the persons or organizations I authorize below are not healthcare providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

This authorization will remain in place until a notice of change is provided in writing.

Protected Health Information to Be Used and/or Disclosed:

- I authorize Urology Associates of SENC, PA to discuss medical information regarding my care, test results, appointments and /or billing information with someone other than myself. **Yes** ☐ **No** ☐
- If yes, I authorize Urology Associates of SENC, PA to disclose my protected health information to the following individuals, who may be contacted directly by Urology Associates of SENC, PA.

Name	Relationship	Phone Number

- I authorize Urology Associates of SENC, PA to leave a message regarding my medical care on my voicemail. **Yes** ☐ **No** ☐
- I authorize Urology Associates of SENC, PA to send appointment reminders via Text Message. **Yes** ☐ **No** ☐

If yes, please provide the phone number: _____

**Please note data charges may apply per your cell phone carrier*

I acknowledge that I have been made aware of Urology Associates of SENC, PA's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Urology Associates of SENC, PA's Notice of Privacy Practices.

_____ _____

Signature Date

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:	
Relationship to Patient:	