ALOHA UROLOGY, INC.

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HIPAA

Notice of Privacy Practice Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices which contain a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Privacy Practices from time to time and I may obtain a current copy. Also, I understand I may revoke this Consent in writing at any time. Upon written receipt and confirmation, it shall be revoked.

Patient Name:
_____

Relationship to Patient:
_____

Signature: _____ Date:
_____