Michigan Urological Clinic
Signature Authorization & Confidentiality Form

This authorization form MUST BE SIGNED prior to seeing a physician!

Patient's Name: _____**DOB:** _____**Date:** _____

Release of Information

I authorize the release of any medical information necessary including, but not limited to, any and all information regarding serious communicable diseases and infections as defined by statute and the Michigan Department of Public Health (i.e. VD, TB, Hepatitis B, HIV, Aids, and ARC), or any alcohol or drug abuse treatment information, etc.;

1) To process claims:

   Information released hereunder may be provided to any independent auditors hired or retained by any and all third party payers, private health insurers or any employer for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient. This authorization includes authority to fax such information, if necessary. Moreover, any information released hereunder may be released or communicated verbally, in writing, or through electronic communication (i.e. via telephone, mail, fax, e-mail, etc.).

2) To be referred to a specialist for medical care,

3) To obtain services for lab, x-ray, and other diagnostic services. I also authorize that this information may be faxed, if necessary.

Signature _____Date:_____Relationship:_____

Assignment of Benefits

I authorize that insurance payments of medical benefits be paid directly to Michigan Urological Clinic for the services rendered.

Signature: _____Date:_____Relationship:_____

Responsibility of Payment

I authorize and accept responsibility for payment of any balance of fee; 1) remaining after payment of insurance benefits, 2) not covered by insurance for whatever reason, 3) deemed not covered by workman's compensation, or 4) deemed not covered by auto insurance.

Signature: _____Date:_____Relationship:_____

Responsibility of Patient

I am willing to take responsibility for my own health in such matters as weight, diet, smoking, exercise, alcohol and drug use and in following my doctors' instructions. I understand that abuse in any of these areas may adversely affect my health and treatment.

This release shall be effective only as long as is necessary to accomplish the purpose for which it is given or until it is specifically revoked in writing by the undersigned.

I have read and understand all of the above and agree to the terms set forth by the Michigan Urological Clinic.

Signature: _____ ____Date: _____Relationship: _____

Contact Instructions

YES _____I **authorize** the physicians and staff of MUC to leave information at the designated phone number and/or email address (below) regarding my care including, (but not limited to), scheduled appointments, lab and x-ray results. Results may be given to the individuals answering the phone or left on the message machine.

NO _____I do **not** authorize the physicians and staff of MUC to leave information regarding my health care or scheduled appointments on a message machine or given to any person except myself.

I authorize the physicians and staff of MUC to communicate any and all aspects of my medical care, including but not limited to financial information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I can be contacted at the following phone number: _____.

Email address: _____

The right-to-privacy pledges tell consumers how their private medical information will be used for treatment, billing and business operations. It also spells out what information our office can disclose about our patients. Thank you.

Patient Consent Form

The department of Health and Human services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy, The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signature below is only acknowledgement that you have received this notice of our privacy practices:

Signature_____Date_____