SIOUXLAND UROLOGY ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Siouxland Urology Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) Siouxland Urology's Notice of Privacy Practices provides a more complete description of such uses and disclosures and is available in our waiting room, or ask the receptionist for a copy.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Siouxland Urology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding written request to Siouxland Urology 455 Sioux Point Road, Dakota Dunes, SD 57049.

With this consent, Siouxland Urology may call my home or other alternative location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Siouxland Urology may email, mail or text message any items that assist the practice in carrying out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Siouxland Urology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do night sign this consent, or later revoke it, Siouxland Urology may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date of Birth Printed Name Date

PLEASE LIST NAMES AND RELATIONSHIPS OF OTHERS THAT YOU WISH TO BE ABLE TO DISCUSS YOUR MEDICAL CARE AND BILLING QUESTIONS WITH.

NAME:	RELATIONSHIP:
_____	_____
_____	_____
_____	_____
_____	_____