

BELLEVUE UROLOGY ASSOCIATES, INC. PS
Notice of Privacy Practices
Acknowledgement

We keep a record of the health care services we provide our patients. The record is compiled by us and is our property, but you may ask to receive a copy of it. We will need two weeks advance notice and a written release to make a copy for you. You may also ask to correct any factual mistakes you believe to be in the record once you have reviewed it. We will not disclose your record to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. You may obtain further information about these matters by contacting our Privacy Officer at (425) 454-8016.

Our **Notice of Privacy Practices** brochure describes in more detail how your health information may be used and disclosed, and how you can access your information. Please inform the Front Desk Receptionist if you would like a copy of the brochure.

By my signature below, I acknowledge that I am aware that the Notice of Privacy Practices brochure is readily available to me upon request.

Signature of Patient or Authorized Representative

Date

Please Print the Name Signed Above

Relationship (parent, legal guardian, personal representative, etc.)

CONSENT TO LEAVE MESSAGES

I, _____, give Bellevue Urology Associates, Inc. permission to:
Printed Name

Leave a message regarding my upcoming office visit,
account information, and/or test results on my
answering machine.

YES ___ NO ___

Leave a message with anyone who may answer
the phone at my residence.

YES ___ NO ___

Leave a message at my place of employment.

YES ___ NO ___

Signature

I authorize Bellevue Urology Associates to disclose information and/or review my care with:

NAME:

RELATIONSHIP:

Signature

This form will be retained in your medical record.