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HIPAA NOTICE OF PRIVACY POLICIES

Patient Name: ____ Date of Birth: ___________

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of my notice and I request the following restriction(s) concerning the use of my personal medical information. I authorize the following person(s), other than myself, to inquire about and receive medical information regarding my care at **N.E.O. Urology Associates, Inc.**

Name: ______________________________ Relationship: _________ Phone #: _______________

Name: ______________________________ Relationship: _________ Phone #: _______________

Name: ______________________________ Relationship: _________ Phone #: _______________

Name: ______________________________ Relationship: _________ Phone #: _______________

I understand that any person(s) not mentioned above, will not be given any information regarding my status as a patient at **N.E.O. Urology Associates, Inc.**

Patient Signature: ____ Today's Date: __________

*Please provide an email address below to register for our Patient Portal to see results and message the office. Zoom internet emails are **not** compatible.*

Email Address: ____