PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Urology Associates of San Luis Obispo, A Medical Corporation, Inc. to use and disclose **"Protected Health Information" (PHI)** about me to carry out **"Treatment, Payment and Healthcare Operations" (TPO)**.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Urology Associates of San Luis Obispo, A Medical Corporation, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Urology Associates of San Luis Obispo Privacy Official at 3599 Sueldo St, Suite 110, San Luis Obispo, CA 93401**.

With this consent, Urology Associates of San Luis Obispo, A Medical Corporation, Inc. may call my home or other alternative location and leave a message on voice mail or in person 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 information.

With this consent, Urology Associates of San Luis Obispo, A Medical Corporation, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, letters, lab results and orders.

With this consent, Urology Associates of San Luis Obispo, A Medical Corporation, Inc. may disclose PHI for clinical trials and research.

I have the right to request that Urology Associates of San Luis Obispo, A Medical Corporation, Inc. restrict how it uses or discloses my PHI to carry 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 Urology Assoc of San Luis Obispo'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 not sign this consent, or later revoke it, Urology Associates of San Luis Obispo, A Medical Corporation, Inc. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian