Michael P. Verni, MD, FACS

Authorization to Release or Use Information for Treatment, Payment or Health Care Operations

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Advanced Urology of Central Florida (the “practice”) in order to carry out treatment, payment, or health care operations. You should review the Practice’s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practice, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations, our practice is not required to agree with such restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practices.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family member, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf.

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I agree that the Practice may disclose the following types of information contained in my medical record (please Initial the appropriate categories listed below):

______ HIV/AIDS Information
______ Mental Health Information
______ Substance Abuse Information
______ Sexually Transmitted Disease Information
______ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the appropriate spaces below):

______ Via e-mail to the Patient’s designated e-mail address which is: (I am responsible for notifying the Practice of any changes to my e-mail address) ____
______ Via regular mail with any envelopes being marked personal and/or confidential and addressed to me.
______ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier)
______ Via fax to my designated fax number which is: ____________________________________
At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

______________________________________ ______________________________________
Signature of Patient or Authorized Representative   Print Name

______________________________________ ______________ ______________ AM / PM
Representative relationship to Patient   Date   Time

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