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THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (S160.103)

Defines individual health information, including demographic information collected for an individual and:

1. Created or received by a health care provider, health plan, employer, or healthcare clearing house; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual.
3. The information therefore identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

Permitted disclosures (S164.502) and uses by a health care provider include:

1. For treatment, payment or health care operations as permitted under this law.
2. Uses or disclosures to a personal representative assigned by the patient.
3. Disclosure to the parents or persons acting loco parentis to an un-emancipated minor.
4. For case management or care coordination for the individual or to directly recommend alternative treatments, therapies, health care providers, health care settings.

Name of Patient: Date:
Patient Social Security: Date of Birth

I, **Paul S Conner** am a patient of Bay Urology Center; I understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time. This disclosure is effective April 14, 2003. This facility has provided me with a list of all the persons, agencies, or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND ASSIGN THE FOLLOWING:

TRUSTEE: (Family member, lawyer, other who can access my medical information)

1. Name: Phone:

2. Name: Phone:

3. Name: Phone:

ASSIGNMENT OF BENEFITS SIGNATURE
AUTHORIZATION FOR MEDICARE A AND B AND COMMERCIAL INSURANCES

I, **Paul S Conner**, authorize Bay Urology Center, or any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers for Medicare claims or to my insurance company or its representatives, any insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be paid directly to the center who accepts assignment. This assignment will be a lifetime authorization.

Date Signed:

Signature if by other than the patient Reason patient unable to sign

This document has been electronically signed by <Approved By> on <Approved date time>.