ARIZONA CENTER FOR
VASECTOMY & UROLOGY, P.C.

Peter J. Burrows, M.D.

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information (HIPPA)

PATIENT NAME: ____________________________ DOB_____________ DATE ___________

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain Patient Rights regarding my protected health information.

Arizona Center for Vasectomy and Urology, P.C. has a detailed document called "Notice of Privacy Practices" it contains a complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the NOTICE before signing this agreement.

If you need to a copy of this agreement; Arizona Center for Vasectomy & Urology will be glad to provide you the most current Notice of Privacy Practices.

I understand that Arizona Center for Vasectomy and Urology may use or disclose my protected health information for treatment, payment, or healthcare operations, unless required by law; there will be no other uses and disclosures of this information without my authorization.

I give consent for my medical information to be shared with: _____________________

Relationship: ________________________

My signature below indicates that I have been given the chance to review such a copy of the Notice of Privacy Practices.

____ ________________

Signature (patient or legal custodian/ authorized representative) Date

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