

FOOTHILLS UROLOGY, P.C.
400 Indiana Street, Suite 300
Golden, CO 80401

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I UNDERSTAND THIS INFORMATION SERVES AS:

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source for applying my diagnosis and surgical information to my bill.**
- **A means by which a third party payor can verify billed services were rendered.**
- **A tool for ensuring quality of care and competency of healthcare professionals.**

I UNDERSTAND I HAVE THE RIGHT:

- **To object to the use of my health information for directory purposes.**
- **To restrict how my healthcare information is used or disclosed in my treatment plan.**
- **To revoke this consent in writing, except to the extent that Foothills Urology has already taken action in reliance thereon.**

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE/DISCLOSURE OF MY HEALTH INFORMATION:

Patient Signature

Date
