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## NOTICE OF PRIVACY PRACTICES:

### *Acknowledgement of Receipt*

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/parent/conservator/guardian)

<b>INABILITY TO OBTAIN ACKNOWLEDGEMENT</b>
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To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of MUS representative: \_\_\_\_\_ Date: \_\_\_\_\_

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