Reno Office
5560 Kietzke Ln
Reno, NV 89511
(775) 322-7811

Sparks Office
5070 Ion Dr, Suite 201
Sparks, NV 89436
(775) 322-7811

Oncology Nevada
10745 Double R Blvd
Reno, NV 89521
(775) 850-6505

Patient Privacy Policy (HIPAA)

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATON

Urology Nevada and Oncology Nevada are required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the Notice of Privacy Practices folder, copies of which are available by request from the front desk. You may revoke this consent at any time; however, we require that you must revoke this consent in writing. If you choose to revoke this consent, the revocations will not affect the use and disclosure prior to the date of your request. Your protected health information will be disclosed to others by Urology Nevada for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Urology Nevada and Oncology Nevada reserve the right to change or modify the privacy practices outlined in the Notice of Privacy Practice folder and will notify you of any changes of privacy practices by mail, at your next appointment, other pre-approval method you request.

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the following notice. We require your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your health care. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

Acknowledgement: I have reviewed this consent for and the Notice of Privacy Practices and give my permissions to Urology Nevada and Oncology Nevada to use and disclose my health information in accordance with the consent and notice provided.

Please indicate to whom you would like to release your personal medical Information: **(Please print full legal name)**

( ) Other providers/ doctors/ hospitals

( ) Spouse: _____ Relationship: _____

( ) Family Member: _____ Relationship: _____

( ) Family Member: _____ Relationship: _____

( ) Other please specify name: _____ Relationship: _____

THE ABOVE AUTHORIZATIONS ARE REVOCABLE AT ANYTIME

_____ _____

Patient printed legal name

Guardian printed legal name

_____ _____ _____ _____

Patient signature Date Guardian signature Date