

**THE UROLOGY CENTER OF CHESTER COUNTY, PC**

**CONSENT TO USE AND DISCLOSE HEALTH INFORMATION Explanation - Read before signing the consent**

This consent authorizes The Urology Center of Chester County, PC to use and disclose health information about you for treatment, payment, and health care operations.

The Urology Center of Chester County, PC has a Notice of Privacy Practices, which describes how we use and disclose protected health information about you and how you can access your protected health information. You may review our current notice prior to signing this consent.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain. You may obtain a revised notice by submitting a written request to our Privacy Officer.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree to any requested restrictions. However, if we agree to a requested restriction, we are bound by the restriction.

You have the right to revoke this consent, except to the extent that we have taken action in reliance on the prior consent. To revoke this consent, you must submit a written revocation to our Privacy Officer.

**Current contact information for our Privacy Officer**

The Urology Center of Chester County, PC  
Attention: Privacy Officer  
915 Old Fern Hill Road, Building B, Suite 202, West Chester, PA 19800  
Telephone: 610-692-4270  
Facsimile: 610-692-2566

**Consent**

Print or type all information except the signature.

I have read and understand the above Explanation and have been provided the opportunity to review the Notice of Privacy Practices for The Urology Center of Chester County, PC prior to signing this consent. The Urology Center of Chester County, PC is authorized to use and disclose health information about

\_\_\_\_\_ (patient name) for treatment, payment, and health care operations in accordance with its Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient  
(or patient's personal representative)

\_\_\_\_\_  
Date

Personal Representative Information (if applicable):

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient (or other authority to serve)