NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I have received the Practice’s Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

- I authorize Urologic Specialists of Northwest Indiana, to use my email address: □ Yes □ No This information will be held in strict confidence by Urologic Specialists of Northwest Indiana.
  
  Email address: ________________________________________________

- In accordance with Indiana law, this notice is to advise you that your physician may have an ownership interest in:
  
  United Shockwave Therapies, LLC
  Community Surgery Center, LLC
  Pinnacle Hospital

  You have the right to be referred to another entity other than the entity in which your physician has a financial interest for the provision of services.

- The undersigned hereby acknowledges receipt of this notice on the date set forth below.

  Patient name:_____________________________________________________

  Patient signature:____________________________ Date:_________________