UROLOGY CARE SPECIALISTS

1601 CLINT MOORE ROAD, SUITE 195
BOCA RATON, FL 33487

HIPAA / SUMMARY OF NOTICE OF PRIVACY PRACTICES

I, ____ have recelved a copy of Dr David Schwartzwald's summary of **Notice of Privacy Practices**.

Optional Disclosures:

_____ Home Phone/answering machine _________________________________

_____ Cell Phone _________________________________

_____ Work Phone _________________________________

Dr David Schwartzwald's office has my permission to release information regarding my medical condition to the following:

_____ **My Spouse** ____
Print Name Contact Number

_____ **Family Member/Other** ____
Print Name Contact Number

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Print Name Contact Number

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Print Name Contact Number

____
Print Name Contact Number

I authorize Dr David Schwartzwald's and / or his designated staff to obtain medical information from my physician as he deems necessary to ensure continuity of my medical treatment. I also authorize Dr David Schwartzwald, and / or his designated staff to obtain my medical records from any medical facility including but not limited to hospital, diagnostic imaging centers and laboratories.

This authorization will remain valid for as long as i am a patient of Dr David Schwartzwald and / or his practice.

____ ______________________
Signature of Patient Date