Windward Urology Associates Ltd
Ellerslie School Road, Black Road
St. Michael, Barbados
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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Windward Urology Associates Ltd/Dr. John Franklin originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party can verify that services billed were actually provided,
- And a tool for routine healthcare operations such as assessing quality and reviewing the
- competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to
- carry out treatment, payment or health care operations.

I understand that Windward Urology Associates Ltd/Dr. John Franklin is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizations has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by law.

I further understand that Windward Urology Associates Ltd/Dr. John Franklin reserves the right to change their notice and practices and prior to implementation. Should Windward Urology Associates Ltd/Dr. Franklin change their notice, they will send a copy of any revised notice to the address I've provided (whether mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient Signature_____ Date_____

FOR OFFICE USE ONLY

- Consent received by_____ on_____
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____