Texas Center for Urology

David Rittenhouse, D.O., F.A.C.O.S.
Todd E. Young, D.O., F.A.C.O.S.
Michael G. Waters, D.O., F.A.C.O.S.
James J Kelley IV, D.O.

Keith DeSonier Jr., PA-C
Kevin Schmitz, PA-C
Abby Cahill, PA-C
Trang Trinh, APRN-NP-C

Fort Worth Office:
2900 Acme Brick Plaza
Fort Worth, TX 76109
(817)871-9069
Fax: (817) 871-9067

Burleson Office:
11797 South Fwy, Ste. 330
Burleson, TX 76028
(817)769-3370
Fax: (817)769-3377

Weatherford Office:
2107 FTW Hwy
Weatherford, TX 76086
(817)871-9069
Fax: (817)871-9067

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print) Date of Birth

Signature of Patient Date of Signature

Signature of Patient Representative (Required if the patient is a minor or adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? YES NO N/A

May we leave **messages** on a voice mail at your work? YES NO N/A

May we discuss your **appointments/treatments** with your spouse? YES NO N/A

If you are over the age of 18 and still living at home, may we discuss your **appointments and/or treatments** with your parent(s) or guardian? YES NO N/A

If you are over the age of 18, may we discuss your **appointments and/or treatments** with your children? YES NO N/A

I authorize the following people to discuss/receive information regarding my care:

_____

_____

You must inform us **in writing** if you wish to change the manner in which this office communicates with you.
Thank You.