Form U

UROLOGY GROUP OF NEW JERSEY, LLC
(THE "PRACTICE")]

Notice of
Disclosure of Health Information to Family and Friends Involved in Your Care and Your Right to Object

Communications with Family Members/ Caregivers

In an effort to promote effective communication between the Practice, its patients and family and friends involved in a patient's care or payment of care and in recognition of the important role that family members, friends and others play in a patient's care or payment of care, it is the policy of the Practice to communicate to family members, friends or any other person(s) you may identify, information about you that is directly related to that family member's, friend's or caregiver's involvement in your care or payment of care. Unless you object and direct us otherwise by checking the box below, we will communicate with your family or friends that information about you that is directly related to their involvement in your care or payment for care.

☐ I DO NOT want the Practice communicating any information to my family or friends. By checking this box I understand that I am limiting the Practice's ability to communicate information about me to my spouse, children, significant other or other person(s) who may accompany me to a procedure or call or seek to act on my behalf or who otherwise may be involved in my care or the payment of my care.

By signing below, I acknowledge receiving and reading this Notice.

_____ _____
Print Name Signature

Date_____

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