ANDROLOGIX™
HEALTH AND WELLNESS

Please read, sign, and fax to (561) 658-6212

Most patients are very anxious to hear the results of their lab tests or other determinations made by our medical staff regarding their treatment. Due to a physician's schedule, communication of the results, especially if they are within normal ranges, is sometimes delayed. Although all Andrologix Health and Wellness personnel, both professionals and non-professionals, are part of the Health Care Operations of the practice, and therefore do not require a specific HIPAA consent form, Andrologix Health and Wellness takes the confidentiality of your personal health information very seriously and does not permit its personnel who are not directly involved in your medical assessments and treatment with access to your medical records without your written consent. By signing this form, you will give permission to allow your Andrologix advisor, or other administrative staff member, to communicate to you via phone, email, in writing, or in person, protected health information pertaining to your medical care.

This consent form does not allow Andrologix Health and Wellness to share your health information with any third-party for any reason. It simply authorizes our administrative staff to convey information from our medical staff to you, at your request. I further understand that administrative staff cannot answer specific questions about the meaning of the results or treatment modalities, and if I have such questions after receiving the results, the administrative staff will have a physician or other qualified health professional contact me to answer my questions.

Authorization for Andrologix to Release Health Information to Myself

I, the undersigned patient, hereby give my consent for Andrologix Health and Wellness, its parent company Sozo Group LLC, and their non-professional and administrative staff to use and disclose my protected health information (PHI) to me in order to carry out health care operations pertaining to my medical results and treatment.

With this consent, my Andrologix advisor, or other administrative staff, may communicate to me by phone, email, in writing, or in person, information that assists the practice in carrying out operations related to my treatment; such as, appointment reminders, billing issues, and communications related to my clinical care, including laboratory test results. I acknowledge that such advisor or staff cannot answer specific questions about the results or course of my treatment as they are not a health professional, and any opinions and/or casual conversation they might gratuitously offer are not to be construed as medical advice, and that I can request a physician or other health professional to contact me to answer my questions.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that this form is not required under the HIPAA privacy rule, but if I choose not to consent, or later revoke consent, Andrologix Health and Wellness may be unable to continue to provide treatment to me, but they will not do so without affording me a reasonable time, not longer than thirty days, to obtain a successor physician/practice.

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Patient's Signature

_____ _____

Patient's Printed Name **Date signed**