

DuPage Urology Associates, Ltd.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**I have received the DuPage Urology Associates, Ltd.
NOTICE OF PRIVACY PRACTICES.**

Signature of Patient

Date

Print Name

Date of Birth of Patient

Signature of Parent / Legal Guardian
or representative

Relationship to Patient

Witness

Date