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# N.E.O. Urology Associates, Inc.

7430 Southern Blvd.  
Boardman, Ohio 44512  
(330)729-9214  
(330)729-9217  
[info@neourology.com](mailto:info@neourology.com)

6262 Mahoning Ave. Ste. C  
Austintown, Ohio 44515  
(330)779-6851  
(330)270-3484  
[info@neourology.com](mailto:info@neourology.com)

[www.neourology.com](http://www.neourology.com)

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Richard A. Memo, M.D. F.A.C.S.

Robert R. Ricchiuti, M.D. F.A.C.S.

Vincent S. Ricchiuti, M.D. F.A.C.S.

Daniel J. Ricchiuti M.D. F.A.C.S.

Mark A. Memo D.O. F.A.C.S.

David W. Drevna, M.D.

Cortney Birchak, CNP

## HIPAA NOTICE OF PRIVACY POLICIES

I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

I authorize the following person(s) other than myself, to inquire about and receive medical information regarding my care at NEO Urology, Assoc.:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that any person(s) not mentioned above, will not be given any information regarding my status as a client at NEO Urology Associates, Inc.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PROVIDE E-MAIL ONLY IF REGISTERING FOR OUR PATIENT PORTAL.

E-MAIL: \_\_\_\_\_