PRECISION UROLOGY

Authorization to Share Health Information with Family Members or Friends

(This form does NOT authorize release of copies of the medical chart)

Patient Full Name:_____ Date of Birth: _____

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss their medical/billing information, request prescriptions; medical records and results of tests also pick up forms, etc. Under the requirements of HIPAA, we are not permitted to release this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members or friends, you must sign this form.

☐ I decline to have my medical information discussed with family and friends.

☐ I give permission to Precision Urology PLLC to discuss my health information listed above to the following individuals:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

I understand I must sign a separate authorization form releasing copies of my medical record to another individual.

I understand I have the right to revoke my permission at any time except where Precision Urology PLLC has already made disclosures in reliance upon this request. I understand this this permission remains in effect until the time I revoke in writing.

_____

Signature of Patient/Person Representative Date