Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call or request medical information about you. This information may include the results of tests, procedures, appointments, insurance and billing & payment information. Due to privacy and security rules associated with HIPAA, we are not allowed to provide this information to anyone without the patient's written consent. If you wish to have your medical information, appointment information, the results of any diagnostic test results and/or financial information released to any family members you must provide written consent by signing this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures based upon your prior consent.

I authorize Urology Associates of Mobile, PA to release my records and any information requested to the following individuals:

1. ____ Relation to patient: ______________________
2. ____ Relation to patient: ______________________
3. ____ Relation to patient: ______________________
4. ____ Relation to patient: ______________________

Authorization Regarding Messages and Voicemail:
(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

____ I authorize you to leave a message only asking me to return your call

____ Messages may only be left with: ____

Please call: my home _________________my work __________________my cell: ___________________

The best time to reach me is on (day) ____________________ between (time) _________and_________

____ ____
Patient Name (PLEASE PRINT) Date

____
Patient Signature