PACIFIC NORTHWEST UROLOGY SPECIALISTS PLLC

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CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

I, _____ **(print patient name)** understand that my healthcare information at Pacific Northwest Urology Specialists, PLLC is protected and I have received a copy of their Notice of Privacy Practices. In order for Pacific Northwest Urology Specialists to leave detailed messages on my voicemail or answering machine, I need to give permission for them to do so.

Consent for Leaving Messages:

☐ I consent to information regarding my (or my child's if under the age of 18) test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that "sensitive" information as noted below will be excluded.

Consent for Shared Information with Family and Friends:

☐ I wish family members or friends to have access to my healthcare information. Name(s) listed below are the people to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

I understand that some information is considered "sensitive". I understand that I must check the specific boxes in order for my provider, or his/her designee, to release any "sensitive" information.

☐ Mental Health/Psychiatric Disorders (including depression)

☐ Chemical Dependency

☐ Sexually Transmitted Diseases

☐ Pregnancy

☐ HIV / AIDS Virus

NAME	RELATIONSHIP
1) _____	_____
2) _____	_____

_____ _____

Patient/Parent Signature **Patient DOB** **Today's Date**

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.