UROLOGY SPECIALISTS

Patient Name:

_____

DOB: _____

MRN: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS Date: _____

I, _____ , hereby request that Urology Specialists keep communications regarding my protected health confidential. To accomplish this, please adhere to the following:

You may contact me by telephone at the following numbers:

Home: _____ Message Yes/No

Work: _____ Message Yes/No

Cell: _____ Message Yes/No

What is the preferred number to be used for communication? _____

Nursing/Group Home or Assisted Living: _____

You may leave messages with/release verbal information to the following individuals:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

***** Patient signature:** _____

Patient Representative Signature: _____

If you are not the patient, please specify your relationship to the patient: _____

HIPAA Privacy Policy & Patient Rights

I understand that a copy of the HIPAA Privacy Policy, Patient Rights pamphlet is available to me upon request.

***** Signature:** _____ **Date:** _____

Assignment Authorization

I authorize my insurance benefits be paid to Urology Specialists and recognize that I am financially responsible for any balance. I authorize release of information requested by the insurance companies.

***** Signature:** _____ **Date:** _____