Valley Urological ASSOCIATES

Competence, Compassion...Convenience
Trusted expertise, close to home™

Date: _____

CONSENT FOR PHONE CONTACT

In an effort to give you the best possible patient care, it is often necessary to leave a message at your home regarding test results or more often, an upcoming appointment. Please read the following and check **all** that apply.

- ❑ I prefer all discussions and/or confirmation of appointments be given only to me. If I am not available, you may leave a message for me to call you back.
- ❑ You may leave test results or confirm appointments with **any** member of my family.
- ❑ You may leave test results or confirm appointments with (a specific person):

  Print name of person _____
- ❑ You may leave test results, confirm appointments, etc. on my voice mail.

RELEASE OF MEDICAL OR BILLING INFORMATION

In addition to the uses and disclosure of my information as described in the Valley Urological Associates Privacy Policy and Practices I, _____, authorize Valley Urological Associates and/or ECP services (billing service for Valley Urological) to discuss/release my medical information and/or billing information with the following individuals.

Name	Relationship to Patient	Medical	Billing
		(check all that apply)	
_____	_____	❑	❑
_____	_____	❑	❑

- ❑ Other than the uses and disclosures of my information as described in the Valley Urological Associates Privacy Policy and Practices, please do not give out medical information about me and do not discuss my medical financial situation with anyone other than myself.

Signature: _____