Bellingham Urology Group PLLC

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

I, _____ **(print patient name)** understand that my healthcare information at Bellingham Urology Group, PLLC is protected and that I have received a copy of their Notice of Privacy Practices.

In order for Bellingham Urology Group to leave detailed messages on my voicemail or answering machine, I need to give permission for them to do so. I have checked the box(es) next to the sentence(s) that reflect my wishes.

Decline to have messages left:

☐ I *do not* want to have messages left on my voicemail or answering machine or to have information left or discussed with anyone other than myself. I understand that I may miss calls from the clinic regarding test results or appointment reminders or instructions.

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 unless checked.

My preferred means of contact is: ☐ Text Msg ☐ E-mail ☐ VoiceMail _____
Phone # or E-mail Address

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

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.

NAME	**RELATIONSHIP**
1) _____	_____
2) _____	_____

_____ _____

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