Bellingham Urology Group PLLC

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Consent to Leave Messages and Share Information

Print Patient Name: _____Patient Date of Birth:_____

1. 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 next to the sentence that reflects my wishes.

Decline to have messages left:

☐ I *do not* want to have messages left on my voicemail or answering machine. I understand that I may miss calls from the clinic regarding test results or appointment reminders or instructions. I understand that I am responsible for missed appointment fees.

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.

2. My preferred means of contact for appointment reminders is: ☐ **Text** ☐ **E-mail** ☐ **Phone call**
Phone # or E-mail address: _____

3. In order for Bellingham Urology Group to share healthcare information and appointment information with my friends or family, I need to give permission for them to do so. I have checked the box next to the sentence that reflects my wishes.

Consent to share information with friends or family:

☐ I wish family members or friends listed below to have access to my healthcare information. The 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)	_____	_____
3)	_____	_____

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 the following "sensitive" information:

☐ Mental Health/Psychiatric Disorders (including depression)
☐ Chemical Dependency
☐ Sexually Transmitted Diseases
☐ Pregnancy
☐ HIV/AIDS Virus

Decline to share information with friends or family:

☐ I *do not* want to have my healthcare information or appointment information shared with family or friends.

By signing below, I confirm that I have read and completed this entire form:

_____

Patient/Parent Signature **Today's date**