ASSOCIATED UROLOGISTS OF NORTH CAROLINA, PA

Contact Information for Protected Health Information

I,____Date of Birth:________________________

Request that the following be followed for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnosis (es), test results, dates of service).

(Please check all that apply)

☐ You may disclose information to my family members below.

Name	Phone Number	Relationship

☐ You may leave Protected Health Information on my answering machine/ voicemail.

Phone Number: ____

☐ Other: ____

______________________________________ PATIENT'S PRINTED NAME

______________________________________ PATIENT SIGNATURE

______________________________________ OFFICE WITNESS

______________________________________ DATE