

Urological Consultants, P.A.

Receipt of Notice of Privacy Practice

I, _____, have received a copy of Urological Consultants Privacy Notice.

* _____ *
Signature of Patient/Legal Guardian Date

_____ Patient Refused to Sign Employee Signature _____

Request for Protected Health Information

Who may we release your personal and medical information to, other than yourself and medical professionals

Please include the relationship to the patient.

Please indicate where it is OK to leave you a detailed message:

HOME WORK CELL (Please circle all that apply)

* _____ *
Signature of Patient/Legal Guardian Date

(For Use by Employees of UCPA Only)

Indicate which Photo ID has been checked:

Driver's License _____ State: _____ Date Checked: _____

State ID _____ State: _____ Employee Initials: _____

Military ID _____

Other _____ Specify: _____