UROLOGIC SPECIALISTS

HIPAA Questionnaire

Date: _____ Account #: _____

Patient Name: _____ Date of Birth: _____

***How do you prefer we contact you regarding appointments?**

Home _____Work _____Other Number_____

May we leave a message on this phone? Yes _____ No_____

***How do you prefer we contact you regarding test results?**

Home _____Work _____Other Number_____

May we leave a message on this phone? Yes _____ No _____

***Who do you authorize to receive your information?**

May we share information about your care with anyone such as a family member, caretaker or close friend?"

Name, Address, and Phone Relationship

_____ _____

_____ _____

_____ _____

Please specify what to share:

_____ Entire Medical Record _____ Appointment Information

_____ Test Results _____ Other: _____

***This Authorization will Expire (must choose one):**

_____ 12 months from date signed _____Until Revoked

Right to Revoke

I understand this authorization is voluntary. I may change this authorization at any time by writing to the address listed at the top of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

_____ _____

Signature (Patient or Legal Representative) Date

_____

Printed Name (Patient or Legal Representative) (06/2016)