UROLOGIC SPECIALISTS

HIPAA Questionnaire

Patient Name: _____ Date of Birth: _____ Account #: _____

COMMUNICATION FROM OUR OFFICE

How do you prefer we contact you regarding matters pertaining to your care?

☐ Home Phone _____

☐ Cell Phone _____ Are we allowed to send appointment info or a request for you to call us VIA text? ☐ Yes ☐ No

☐ Patient Portal

☐ Other: _____

If we are unable to reach you, may we leave a message?

☐ Yes, you may leave a detailed message.

☐ Yes, but only to return your call.

RELEASE OF VERBAL INFORMATION

Please list who are we allowed to speak with and what information we are allowed to give. Spouse, family members, caregiver, or etc.?

Name: _____ Phone Number: _____ Relationship: _____
☐ Appointment Information ☐ Billing ☐ Test Results ☐ ALL

Name: _____ Phone Number: _____ Relationship: _____
☐ Appointment Information ☐ Billing ☐ Test Results ☐ ALL

Name: _____ Phone Number: _____ Relationship: _____
☐ Appointment Information ☐ Billing ☐ Test Results ☐ ALL

Do we have consent to import your medication list from your pharmacies? ☐ YES ☐ NO

Right to Revoke

I understand this authorization is voluntary. I understand I cannot restrict information that may have already been shared based on this authorization. I understand this authorization will remain in effect until terminated by the patient or the patient's representative in writing ***OR*** until a new form is completed and signed.

PLEASE NOTE: This form does not serve as a medical record release. For copies of your medical records or to release your records to a 3rd party you will need to fill out a Medical Release Form.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Patient or Legal Representative Relation to Patient