Urology of Indiana

www.urologyin.com

Contact Information for Protected Health Information

I, _____ DOB: _____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 (please list name, phone number, and relationship)

Name	Phone Number	Relationship

- ❑ You may leave Protected Health Information on my answering machine/voicemail
  Phone Number: _____

- ❑ Other: _____

_____ _____

PATIENT'S PRINTED NAME SOCIAL SECURITY NUMBER

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) DATE

_____ _____

WITNESS (Optional) DATE