

Your right to privacy restricts our office's methods of contacting you without your permission. Please answer the following questions in order for us to contact you regarding your medical treatment.

- **Urology Associates has my permission to leave messages on my answering machine at home.**

Yes

No

- **Urology Associates has my permission to leave messages on my answering machine at work.**

Yes

No

- **To whom may we release your medical information (i.e. spouse, children, doctor, relatives, friends)? Please list name and relation:**

Patient's Name _____ **Date:** _____

Patient's Signature: _____

Thank you for your assistance in helping us maintain your privacy.

If at any time you need to change this information, please contact our office.