

Eastern Urology Associates P.A.

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PATIENT CONTACT FORM

Eastern Urology Associates, PA is committed to the protection of the PRIVACY of your PROTECTED HEALTH INFORMATION (PHI). Federal Regulations provide you with certain rights with regard to how we disclose your information, and to who your information may be disclosed. For a complete explanation of your rights and obligations, please see our NOTICE OF PRIVACY PRACTICES available at the reception desk or at www.easternuro.com/privacy.shtml.

*****PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY*****

YES NO

 I authorize the physicians and staff of Eastern Urology Associates, PA to discuss details regarding my medical condition, treatment, lab results prescription information, appointments, medical updates and other PROTECTED HEALTH INFORMATION (PHI), without prior authorization, to the following family members or friends.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

YES NO

 The physicians and staff of Eastern Urology Associates, PA may leave lab results on my answering machine.

 The physicians and staff of Eastern Urology Associates, PA may release information to my pharmacy without prior authorization in order to allow call-in prescriptions.

SPECIAL INSTRUCTIONS: _____

My signature below is acknowledgement that I have received a copy of the NOTICE OF PRIVACY PRACTICES and that I agree to the conditions stated in the notice.

Patient Signature _____ Date _____

This agreement will remain in effect until revoked in writing to the attention of our Privacy Officer unless and expiration date and patient signature is indicated below.

Expiration Date (if applicable) _____ Patient Signature _____