

Information Release

Patient Name: _____ DOB: _____

PLEASE NOTE: All of our patients are notified of upcoming appointments in our office via telephone by our automated reminder service.

AUTHORIZATION TO LEAVE MESSAGES

I **DO** authorize the physicians and employees of Western Michigan Urological Assoc., HH Services Bates et al., LLC to leave information regarding appointment changes, laboratory results, x-rays, or other diagnostic tests at the following contact numbers/voicemail:

I **DO NOT** authorize the physicians or employees of Western Michigan Urological Assoc., HH Services Bates et al., LLC to leave any information regarding appointment changes, laboratory results, x-rays, or other diagnostic tests on my answering machine/voicemail.

AUTHORIZATION FOR RELEASE OF INFORMATION

Confidentiality laws require us to obtain your written consent before we can discuss any of your information with your family member(s) or friend(s).

Please choose **ONE** of the following:

- I **DO NOT** authorize verbal information to be released to any individuals.
- I **DO** authorize my information to be released to the following individuals:

Name	Phone Number	Relationship

Patient Signature: _____ Date: _____