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VALLEY UROLOGICAL ASSOCIATES
Urology and Urologic Surgery

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FAX: (412) 741-2102
McKees Rocks (412) 771-3266
FAX: (412) 771-1720

701 Broad Street • Sewickley, PA 15143

Date: _____

Patient Authorization Form
Consent for Phone Contact

In an effort to give you the best possible patient care, it is often necessary to leave a message at your home regarding test results or more often, an upcoming appointment. Please read the following and check **all** that apply.

_____ I prefer all discussions and/or confirmation of appointments be given only to me. If I am available you may leave a message for me to call you back.

_____ You may leave test results or confirm appointments with **any** member of my family.

_____ You may leave test results or confirm appointments with (a specific person)

_____

_____ You may leave test results, confirm appointments, etc. on my voice mail.

RELEASE OF MEDICAL OF BILLING INFORMATION

I, _____, authorize Valley Urological Associates and/or ECP services (billing service for Valley Urological) to discuss/release my medical information and/or billing information with the following individuals.

Name	Relationship to Patient	Medical	Billing
_____	_____	_____	_____
_____	_____	_____	_____

_____ Please do not give out medical information about me nor discuss my medical financial situation with anyone other than myself.

Signature: _____