El Dorado Urology & Prostate Center

CONTACT LIST

Contact Name: ____ ( ) ____________________

Last *First* *M.I.* *Telephone*

Address: ____

City *State* *Zip*

☐Spouse ☐Family (Describe)___________________ ☐Friend ☐Emergency ☐Other (Describe)__________________

Contact Name: ____ ( ) ____________________

Last *First* *M.I.* *Telephone*

Address: ____

City *State* *Zip*

☐Spouse ☐Family (Describe)___________________ ☐Friend ☐Emergency ☐Other (Describe)__________________

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☐Spouse ☐Family (Describe)___________________ ☐Friend ☐Emergency ☐Other (Describe)__________________

1. I hereby authorize El Dorado Urology and Prostate Center to use and disclose my personal health information to the individuals identified on this form.
2. I understand that the individuals identified on this form will be treated by El Dorado Urology and Prostate Center as individuals involved directly in my care and as such El Dorado Urology and Prostate Center will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from El Dorado Urology and Prostate Center.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from El Dorado Urology & Prostate Center will not be affected if I refuse to sign this authorization.

____ ______________________________

Patient Signature Date/Time AM or PM (*circle one*)

____ ______________________________

Personal Representative Signature Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: ______________________________

ACCOUNT: ______________ LOC: ______________

FOR OFFICE USE ONLY

EMPLOYEE INITIALS

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