UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA, LTD.

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Patient Instructions Regarding Personal Health Information

I authorize my Physician, Physician Group or Staff member employed by the Practice to release any and all medical test results or other medical information relating to my treatment to: (Initial all choices that apply)

_____ May leave a message at work to call the physician's office.

_____ May leave a message with a family member for me to call the physician's office.

_____ May give test results/instructions to:

Designee's Name: _____

Relationship: _____

_____ May only release test results to the patient

_____ Other: _____

_____

I understand this information will be used and these instructions will be in effect unless changed or revoked by me either in writing or by completing a new instruction form.

_____ _____

Date Patient (legal representative) Signature

_____

Date of Birth