

**PATIENT CONFIDENTIALITY**  
ASHEVILLE UROLOGICAL ASSOCIATES

Patient Name \_\_\_\_\_  
(please print)

In order to protect your confidentiality, we ask if there is a telephone answering machine or voicemail for you where we can leave results of your laboratory or other tests. Please provide telephone numbers where we may leave confidential health care information messages for you (or write "none" if no messages should be left):

(\_\_\_\_\_) \_\_\_\_\_  
Primary # for Confidential Messages

(\_\_\_\_\_) \_\_\_\_\_  
Alternate # for Confidential Messages

You may designate individuals to request and receive confidential health care information regarding your condition, treatment, payment, account or administrative operations related to treatment and payment. We may verify the identity of these individuals before the release of information. Individuals authorized to receive confidential information:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

I understand these names and numbers will be used until I notify Asheville Urological Associates that it should no longer be used. I have been offered the opportunity and/or have read the Notice of Privacy Practices of Asheville Urological Associates.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date