Advanced Urologic Associates, Inc.

19001 E. 48th St South
Independence, MO 64055
816 251-5100

17525 Medical Center Parkway
Independence, MO 64057
816 251-5100

110 NE Saint Luke's Blvd #120
Lee's Summit, MO 64086
816 251-5100

HIPPA – Patient Consent to Leave Messages

Advanced Urologic Associates, Inc., in order to comply with the HIPPA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Advanced Urologic Associates, Inc., from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Advanced Urologic Associates, physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results to your primary care physician or another physician involved in your care.

I give my consent to Advanced Urologic Associates, physicians and staff to leave a message regarding , treatment, surgery, lab, or radiology results, or other clinical information as necessary (initial all that apply).

_____ **On an answering machine or voicemail at home or cell**

_____ **On an answering machine or voicemail at work**

_____ **With** _____ **relationship**_____

With_____ **relationship**_____

_____ **I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.**

_____ **I give Advanced Urologic Associates permission to leave appointment reminders on an answering machine or voicemail at home or cell.**

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Notes: _____

HIPPA – Notice of Privacy Practice Acknowledgement

_____ I have been provided a copy of Advanced Urologic Associates Notice of Privacy Practice.

_____ I have declined a copy of Advanced Urologic Associates Notice of Privacy Practice.

_____ _____
Patient Signature Date