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## CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

	( <b>print patient name</b> ) understand that my healthcare have received a copy of their Notice of Privacy Practices. In order
for Maui Urology to leave detailed messages on my voto do so.	oicemail or answering machine, I need to give permission for them
Consent for Leaving Messages:	
	ild's if under the age of 18) test results or detailed appointment vering machine. I understand that "sensitive" information as noted
Consent for Shared Information with Family and F	riends:
☐ I wish family members or friends to have access	to my healthcare information. Name(s) listed below are the people
to whom I grant access to my healthcare information. designee to share such information as they deem neces	I will rely on the professional judgment of my provider and his/her sary.
I understand that information is limited to verbal discu information will be provided without my signature on	ssions and that no paper copies of my protected healthcare a Release of Information Form.
I understand that some information is considered "sens for my provider, or his/her designee, to release any "se	sitive". I understand that I must check the specific boxes in order ensitive" information.
☐ Mental Health/Psychiatric Disorders (including d	epression)
☐ Chemical Dependency	
☐ Sexually Transmitted Diseases	
□ Pregnancy	
□ HIV / AIDS Virus	
NAME	RELATIONSHIP
1)	
2)	
2)	
Patient/Parent Signature	Patient DOB Today's Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.