



Allied Urology, P.S.C.

SHARING YOUR HEALTH INFORMATION WITH FAMILY & FRIENDS

Print Name of Patient

To protect the confidentiality of our patients, we ask you to fill out this form. Please indicate with whom you will allow us to discuss your medical care. Any changes made to your designations must be made in writing.

People We May Talk to About Your Medical Care

Name

Relationship

1. _____

2. _____

3. _____

4. _____

5. _____

Signature

Date

To specify person(s) that you do not want your health information discussed with, please ask for a Privacy Restriction form. Thank you.