



# Lubbock Urology Clinic, L.L.P.

## CONSENT FOR SPECIAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I consent to LUC employees identifying themselves and **leaving messages on my answering machine / voicemail** (if I have one) for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you.  
Yes \_\_\_\_\_ No \_\_\_\_\_
2. I consent to LUC employees identifying themselves and **leaving a message with those who answer my home phone** for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you.  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. I consent to LUC employees **contact me at work** (if applicable) for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you.  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. I consent to LUC employees disclosing my private health information, such as test results and billing information with a designated family member or personal representative.  
Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*\* If you answered YES to the above question (#4), please list below the person(s) to whom such information may be enclosed.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Alternate: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**I acknowledge that I have received a copy of the Notice of Privacy Practices, and the above information is correct.**

Date: \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_