Woodfield Urology

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Diplomates of the American Board of Urology - Urology & Urologic Oncology

DISCLOSURE PREFERENCES

We strive to inform our patients of significant medical information or test results in a timely manner. There are laws that prevent us from leaving messages or discussing your medical information with other persons, however, we can disclose your health information with your approval, and if you so choose.

Please indicate ALL acceptable choices by which we may communicate with you regarding your medical information or test results. Please supply us with phone numbers for all applicable options.

__ Patient home answering machine Write # on registration form

___ Patient cell phone voicemail --

___ Patient voicemail at work --

___ Spouse Name_____#_____

___ Next of Kin Name_____#_____

___ Son/Daughter Name_____#_____

___ Parent Name_____#_____

___ Other Name_____#_____

___ Patient will call office

If you wish to make changes to the above information, please contact us at the number below.

_____ _____
Patient Name Patient Date of Birth

_____
Signature of patient or legal guardian Date

_____
If signed by guardian, please print name