

Western Michigan Urological Associates, PLC

Please complete the following information to enable us to contact you. It is important that we be able to contact you to provide laboratory and X-ray results, remind you of a future appointment, or re-schedule an existing appointment.

Patient Name: _____

Primary Contact Number: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I authorize the physicians and employees of Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC to leave information regarding appointments, laboratory results, x-rays or other diagnostic tests at the above designated contact number/answering machine.

_____ YES

_____ **NO** – I understand by checking NO I cannot be contacted by phone about Up coming appointments, appointment reschedules and test results.

I authorize Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC to communicate any and all aspects of my medical care, including but not limited to financial information with :

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

_____ **I DO NOT authorize verbal information to be released to any individual.**

Signature of Patient/Guardian _____ Date _____