UPDATE PATIENT INFORMATION

CONFIDENTIAL COMMUNICATIONS PREFERENCE

You may request confidential communications of Protected Health Information in the method you prefer or at at alternative address. For example, you may not want your appointment or billing statement to be mailed to your home where it may seen by others.

Please select all that applies and sign below:

PROTECTED HEALTH INFORMATION

I Laboratory, X-ray, test results, billing statements, and/or any correspondence pertaining to Protected Health Information; I authorize Dr. Castleberry or the staff members to leave message or mail results unless the following is marked:

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL

☐ DO NOT MAIL RESULTS

II **Authorized Person(s): Person who can receive Protected Health Information.**

Y N Other person(s) authorized: _____

_____

_____

_____

_____

_____

Full Name | Telephone # | Relationship

III **Billing Statements and Correspondence:**

Any correspondence related to your health information will be automatically mailed to your home address, unless other address is given below:

_____

Address | City | State | Zip Code

IIII **Prescription History Release:**

I agree that Starkville Urology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes unless the following is marked: ☐ **NOT AUTHORIZED**

Medical Treatment Consent & Right to Terminate or Revoke Authorization:

This authorization is for medical treatment and effective through indefinitly until revoked or terminated by Patient or Patient's personal representative by a written revocation to Starkville Urology.

_____

PATIENT SIGNATURE (or Legal Representative) | Date

Relationship, if Legal Representative: _____

Thank you for assisting us to serve you more effectively.