

UROLOGY ASSOCIATES OF NORTHEAST FLORIDA, P.A.

TELEPHONE OFFICE POLICY

Please note that due to telephonic legal issues and confidentiality laws it is now required of this office to have a patient and/or parent release and signature in order to confirm, change or cancel office appointments or to be contacted regarding the patient's medical condition.

Please check all the appropriate boxes:

- Office can contact me at my home at _____.
- Office can leave a message at my home with _____ or leave a message on my answering machine at my home telephone number listed above.
- Office can contact me at work at _____.
- Office can leave a message at my work with _____ or leave a message on the answering machine at my work telephone number listed above.
- Office can contact me or leave a voice mail/number on my cell/pager number at _____.
- Office can fax me at home at _____.
- Office can fax me at work at _____.

Signing this notice confirms that I have read this notice and agree with this policy.

Patient and/or Parent if Minor

Date

Witness

Date

Thank you for your help and understanding in these matters