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Urology Practice

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Consent to Release Protected Health Information (PHI)

I authorize Dr. Mugharbil and/or his staff to call my home or other specified location and leave a message on the voice mail, or person answering the telephone in reference to assist Dr. Mugharbil and/or his staff in carrying out Treatment, Payment or Healthcare Operations (TPO), such as appointment reminders.

I authorize Dr. Mugharbil and/or his staff to disclose PHI to include clinical information, laboratory/test results to only those individuals listed below:

Name	Relationship	Telephone

I authorize Dr. Mugharbil and/or his staff to email me to include appointment reminders, insurance information to the email address listed below:

_____@_____

I understand that this consent is good for one year unless I revoke it in writing.

_____ ___/___/___
Patient Signature Date

I <u>DO NOT</u> authorize Dr. Mugharbil and/or his staff to disclose PHI to my spouse or family members.

_____ ___/___/___
Patient Signature Date

Revised: 02/20/2006