Cooper University Urogynecology Associates
Permission Form

Due to new HIPPA regulations, you ***MUST*** give us written permission to leave a message on your home machine or with another person, such as a spouse.

With my consent, University Urogynecology Associates, may call my home and leave a message on my answering machine or with the above listed person(s) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to me clinical care, including laboratory and test results.

I have been offered a copy of the Notice of Privacy Acts and understand my rights as a patient.

To grant permission to leave message or speak with another person please sign here:

_____ Date: _____

Name of person(s) that we are able to leave messages with:

_____ Relationship: _____

_____ Relationship: _____

Phone number you would like messages left on: _____Home/Cell
_____Home/Cell
_____Home/Cell

If you do not give consent please check all boxes that apply:

- ☐ Do not leave negative lab results on my answering machine or with any family member yes____ no____
- ☐ Do not discuss any lab results with anyone but the patient or the patient's parent if the patient is a minor
- ☐ Other restrictions:_____