MIDWEST UROLOGICAL GROUP
DISCLOSURE TO THOSE INVOLVED IN CARE

Our policy at Midwest Urological is to follow the legal aspect of patient confidentiality. Therefore, in order to discuss medical, billing, and treatment with anyone beside yourself either in the office by telephone or email, we need your written consent.

Please fill out the following information:

_____DISCLOSURE ONLY WITH ME

Please print the names and information for people with whom we can discuss your care:

1) _____
**Name Relationship Phone Number Email**

Disclosure type:
_____ Billing Information
_____ Medical Information
_____ Billing and Medical Information

2) _____
**Name Relationship Phone Number Email**

Disclosure type:
_____ Billing Information
_____ Medical Information
_____ Billing and Medical Information

3) _____
**Name Relationship Phone Number Email**

Disclosure type:
_____ Billing Information
_____ Medical Information
_____ Billing and Medical Information

4) _____
**Name Relationship Phone Number Email**

Disclosure type:
_____ Billing Information
_____ Medical Information
_____ Billing and Medical Information

I authorize Midwest Urological to discuss my information with the above names person(s).

_____
Patient Name Date of Birth

_____
Patient Signature Date