



The Urology Division of Integrated Medical Services

Request for Confidential Communication

Patient Name: _____

Date of Birth: _____

I give permission to Arizona Urology to leave a **detailed** voice message in the event that communication needs to take place with me.

Yes

No

If the answer is yes, Please give the phone number that the detailed voice message can be left.

Phone Number: _____

Patient or legally authorized signature

Date

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