

Kulb, Chalian and Leak Urology, Ltd.  
1401 Eastland Dr. Suite B  
Bloomington, IL 61701-3514  
(309) 663-9424

MESSAGE AUTHORIZATION AND/OR FAMILY DESIGNATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Answering Machine/Voice Mail Authorization

Do you give Kulb, Chalian and Leak Urology, Ltd. staff or physicians permission to leave messages on your answering machine or voice mail?

Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse/Family Member Authorization

Do you give Kulb, Chalian and Leak Urology, Ltd. staff or physicians permission to discuss your health care issues with your spouse or other designated persons?

---

Name	Relationship	Telephone
------	--------------	-----------

---

Name	Relationship	Telephone
------	--------------	-----------

---

Signature	Date ____/____/____
-----------	---------------------

---

Witnessed by	Date ____/____/____
--------------	---------------------

---

**Notice and Acknowledgement  
of Privacy Practices**

**Acknowledgement:**

I acknowledge that I have received the attached Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative  
Signature

\_\_\_\_\_  
Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

\_\_\_\_\_