Medical Records Dept Use
Date Rcvd: ______________________
Rcvd by: ________________________
Date Completed: _________________
Completed by: ___________________
Pt Rcvd by P/U Mail

Authorization to Release Medical Information

Patient Name: ______________________________________ Date of Birth: ______________________

I authorize ____
Physician's Name/Facility

to release my protected health information to:

Physician/Facility Name/Self: ____

Address: ____

Phone: ___________________________________ Fax: ____________________________________

I authorize the release of the following information:

☐ All Records ☐ Specific information ____

☐ Billing Records ☐ Specific Treatment dates ________________ to __________________

☐ HIV results. Please initial authorizing our office to release this specific information _________________

Purpose of request:

☐ Continuity of Care ☐ Legal ☐ Personal

☐ Insurance ☐ Other: ______________________

I understand that I may revoke this authorization at any time by notifying Regional Urology in writing of my revocation. I understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation. I understand this authorization will expire one year from the signed date.

Patient Signature: ____ Date: _____________________

Patient Phone: Home ___________________________ Cell: _____________________________________

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