

UNIVERSITY PEDIATRIC UROLOGY, PC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

- DUE TO OUR POLICY OF STRICTLY RELEASING NO INFORMATION TO ANYONE BUT OUR PATIENTS AND/OR THEIR LEGAL GUARDIAN OR PARENT, WE WILL NEED AUTHORIZATION TO DISCUSS ANY INFORMATION CONCERNING PATIENT CARE (INCLUDING APPOINTMENTS, LAB RESULTS, TEST RESULTS, ETC.)
- MEDICAL INFORMATION INCLUDES: ANY PART OF PATIENT'S MEDICAL RECORD AND/OR BILLING INFORMATION.
- THIS AUTHORIZATION WILL REMAIN CURRENT UNTIL WRITTEN NOTICE TO CHANGE, DISCONTINUE OR MODIFY IS RECEIVED BY THIS OFFICE.

UNIVERSITY PEDIATRIC UROLOGY MAY RELEASE INFORMATION (EITHER VERBAL OR WRITTEN) TO THE FOLLOWING PERSON(S):

	NAME(S)
PATIENT	_____
PATIENT PARENTS	_____
PATIENT STEP-PARENTS	_____
GRANDPARENTS	_____
OTHER RELATIVE	_____
FRIEND	_____
NO ONE EXCEPT ME	_____
OTHER	_____

MESSAGES: (IF WE NEED TO CONTACT YOU FOR ANY REASON)

Can messages regarding the patient be left on your answering machine or voice mail either at home or work or with whom ever answers your phone?

Yes _____ No _____ Number _____

Patient's Name _____

Patient's Date of Birth _____

Patient's Social Security Number _____

Signature (if over 18 years) _____

Parent's Name _____

Parent's Signature _____

Date _____

Witness _____ Date _____