Urology Associates Medical Group, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete the following information:

Patient Name_____ Date of Birth ____/____/_____
Address_____City_____State_____Zip_____
SSN_____ Telephone_____

I authorize Urology Associates to disclose/release the following information (check all applicable):

- All Records
- Billing Records
- Laboratory/pathology records
- Other (describe specifically)

Please send the records listed above to (use additional sheets if necessary):

Name_____ Telephone_____ Fax_____
Adress_____City_____State_____Zip_____

Name_____ Telephone_____ Fax_____
Address_____City_____State_____Zip_____

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For my health care
- For payment/insurance
- Other_____

This authorization may not be valid for greater than one year from the date of signature for Wyoming records. I understand that after the custodian of records discloses my health information; it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

Patient/Guardian Signature_____ **Date**_____