Children's Urology Group

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM CHILDREN'S UROLOGY GROUP TO OTHER FACILITIES

(Part of Permanent Medical Record)

Fax #: (813) 877-1397

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient or no longer be protected.

Date: _____

Patient Name: _____ Acct #: _____

Date of Birth: _____ Social Security #: _____

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1) Description of information to be disclosed: _____

_____

_____

2) Person/Organization to receive above information (address):

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

3) This information will be used for the following purpose(s): N/A if requested by patient) _____

_____

4) This consent expires: ____ 30 days from above date ____ Other

(specify other) _____

Signature: _____ Date: _____

Relationship to patient: _____
If personal representative, attach copy of letter of administration.

For office use only: Date of Disclosure: _____

By: _____ Print Name: _____