



# ADVANCED UROGYNECOLOGY

Female Incontinence • Gynecology • Wellness

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

<b>Patient Information</b>	Name _____
	DOB _____ SSN _____
	Maiden/Other Names _____

<b>Provider Who Will Release Information</b>	Name _____
	Address _____
	City/State/Zip _____
	Phone: _____ Fax: _____

<b>Release Records To</b>	Name _____
	Address _____
	City/State/Zip _____
	Phone: _____ Fax: _____

<b>Dates of Treatment</b>	Dates _____
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<b>Purpose of Release</b>	<input type="checkbox"/> Medical Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Patient Request
	<input type="checkbox"/> Other, explain _____		

I understand that my medical record may also include information on the diagnosis/treatment related to psychiatric conditions, drug/alcohol abuse, and acquired immune deficiency. I understand and agree to release my medical information pertaining to any diagnosis/treatment described above, but not limited to such.

I do  do not  authorize this information to be released.

Limitations, if any: \_\_\_\_\_

<b>Time Limit of Request</b>	I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 60 days from the date of signature below.
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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship of Signer to Patient: \_\_\_\_\_