ADVANCED UROGYNECOLOGY

Female Incontinence • Gynecology • Wellness

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information

Name _____

DOB _____ SSN _____

Maiden/Other Names _____

Provider Who Will Release Information

Name _____

Address _____

City/State/Zip _____

Phone: _____ Fax: _____

Release Records To

Name _____

Address _____

City/State/Zip _____

Phone: _____ Fax: _____

Dates of Treatment

Dates _____

Purpose of Release

☐ Medical Care ☐ Insurance ☐ Patient Request

☐ 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: _____

Time Limit of Request

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.

Signature: _____

Date: _____

Relationship of Signer to Patient: _____