ASSOCIATED UROLOGICAL SPECIALISTS

MEDICAL INFORMATION RELEASE AUTHORIZATION

I, _____, authorize AUS to disclose health and medical information to the following individual(s):

_____	_____	_____	Ok to leave a message?
Name	Relationship	Phone	☐ Yes ☐ No
_____	_____	_____	Ok to leave a message?
Name	Relationship	Phone	☐ Yes ☐ No

The following conditions apply to this authorization form:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- We must provide you with a copy of the signed authorization should you decide to release information to other individuals;
- You may refuse to sign this authorization;
- You have the right to revoke this authorization at any time, provided you do so in writing.

I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient Name: _____

Signature: _____ Date: _____

OR

Printed Patient Representative Name:_____

Signature: _____ Date: _____

Description of Representative's Authority: _____