Patient's Request and Authorization for Children's Urology Associates, P.A. to Release Health Information

I request and authorize Children's Urology Associates to provide a copy of the specific health and medical information as described below:

Patient Name: _____ DOB: _____

This Request applies to the following information to be provided one time, as soon as possible:
(select *only one* of the following)

☐ All health information pertaining to any medical history or physical condition and treatment received.
[Optional] Except: _____

☐ Only the following records or types of health information (including any dates):
_____

The designated information should be sent to:

Name: _____

Address: _____

_____

Telephone: (_____) _____

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Signature: _____ Date: _____
(Patient/Parent/Representative/Spouse/Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient: [1]

_____

Witness: _____

_____

[1] A parent, spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a dependent or spouse, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.