

VALLEY UROLOGY

2490 S. Woodworth Loop, Suite 401
Palmer, Alaska 99645

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Office: (907) 745-9300

Fax: (907) 745-9301

Date: _____

Patient Name: _____ Other Names: _____

I am the: _____ PATIENT _____ PARENT _____ GUARDIAN _____ CONSERVATOR _____ DESIGNEE

Date of Birth: _____ Treatment Date: _____

I hereby authorize:

PHYSICIAN (specify) _____

CLINIC (specify) _____

to disclose medical information for the above-named patient.

To Release to: _____

Documents Requested or Released:

- _____ 1. Office Notes
- _____ 2. History & Physical
- _____ 3. Surgical Reports
- _____ 4. Discharge Summary
- _____ 5. Consultation Reports
- _____ 6. Emergency Reports
- _____ 7. Laboratory Reports
- _____ 8. Radiology Reports
- _____ 9. Pathology Reports
- _____ 10. Other (please list)

For the purpose of:

- _____ 1. Further Treatment
- _____ 2. Insurance Claims
- _____ 3. Workers Compensation
- _____ 4. Legal Request
- _____ 5. Other (please list)

I acknowledge that the information to be released **MAY INCLUDE** material that is protected by Federal Law. My **initials** and my signature below authorize release of the following type of information:

_____ Drug/Alcohol abuse _____ Mental Health _____ HIV/AIDS

This consent will expire on _____ or in 90 days from the date stated above, whichever comes first.

Patient signature

Parent, Guardian, Conservator, Designee

FOR HIM USE ONLY / Records released to: Patient _____ Other (define whom): _____

Prepared by: _____ Date: _____

Mailed _____ Faxed _____ Fee Collected \$ _____ MR# _____