UROLOGY CENTER OF ENGLEWOOD

PATIENT AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I hereby authorize employees or other agents of Urology Center of Englewood or _____

to use or disclose the following health information about me:

_____

_____

_____

for the following purposes:

_**X**_ at the request or direction of the undersigned individual

The health information including information relating to diagnosis or treatment of mental illness, or drug or alcohol abuse, and/or confidential HIV information described above may be used by or released to:

_____

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

This Authorization expires:

__ On the following date: _ _ / _ _ / _ _

_____ _____

(Patient Signature) (Witness Signature)

_____

Date

This information has been disclosed to you from records whose confidentiality is protected. Release of medical data includes redisclosure of medical information.