

**SOUTHWEST UROLOGIC SPECIALISTS, P.C.**

6007 E. Baseline Rd. Suite 105 Mesa, AZ 85206

Telephone (480) 897-2727 Fax (480) 892-3035

**Authorization for Disclosure of Patient Health Care Information**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Co

\_\_\_\_\_  
Phone Number

**Authorizes:**

**TO:**

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Patient or Physician

\_\_\_\_\_  
Name of Health Care Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Co

\_\_\_\_\_  
City, State, Zip Co

**INFORMATION TO BE RELEASED: DATE OF INTEREST \_\_\_\_\_ TO \_\_\_\_\_**

COMPLETE RECORDS

LAB REPORTS

X-RAYS / IMAGING REPORTS

OFFICE NOTES

PATHOLOGY REPORTS

OTHER (specify) \_\_\_\_\_

I understand that this authorization shall be valid for one (1) year unless otherwise stated below, or revoked through written notice to medical records.

I understand that my express consent is required to release to any health care information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted disease, psychiatric disorder or mental health or drug use. If I have been tested for any of the above, Southwest Urologic Specialists is specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

I authorize release of my medical records in accordance with specifications listed above. I understand written notice is necessary to cancel this request.

**Patient Signature:**

\_\_\_\_\_  
Date: \_\_\_\_\_

If signed by person other than patient, state legal relationship. Please provide copy of POWER OF ATTORNEY, legal guardianship, ect. If available.

\_\_\_\_\_  
Legal Authorized Representative

\_\_\_\_\_  
Relationship to Patient

Records Prepared and transmitted by:

\_\_\_\_\_  
Date: \_\_\_\_\_

Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness \_\_\_\_\_

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