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
___ X-RAYS / IMAGING REPORTS
___ PATHOLOGY REPORTS
___OTHER (specify) _____
___ LAB REPORTS
___ OFFICE NOTES

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 that 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 _____

Revised 2013