Urology Care PC
6226 E Pima Street Suite 100
Tucson, AZ 85712
Phone 520-298-7200
Fax 520-296-0991

Patient Name: _____ Date of Birth: _____

Release Information To: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Release Information From: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Information Requested:
The information covered by this authorization includes (Please check one)
_____ Entire Medical Record
_____ Information Only, Dates: _____
_____ Operative Note: _____

Purpose of Information: _____

PLEASE INITIAL THE STATEMENT THAT APPLIES:
I do _____ do not _____ authorize:
Any sensitive information my Medical Record may include, but not limited to the diagnosis and treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, AIDS, HIV status and/or STD's. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

This authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this signed authorization by notifying Urology Care in writing. When your medical information is released pursuant to a valid authorization you should be aware of the following; that the information released may be subject to the redisclosure by the recipient and may no longer be protected by the Privacy Rule.

Signature of Patient or Legal Representative: _____
Relationship to Patient: _____ Date: _____