Rupp Urology Clinic

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Authorization for Release of Confidential Information

Patient Name (Please Print): _____

Date of Birth: _____ Social Security #: _____

Legal Guardian (if applicable): _____

Address: _____ City: _____ State: ___ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I authorize the below entity to disclose my health information to:

_____ *Name*	_____ *Name*
_____ *Address*	_____ *Address*
_____ *City, State and ZIP*	_____ *City, State and ZIP*
_____ *Phone Number*	_____ *Phone Number*
_____ *Fax Number*	_____ *Fax Number*

For the following designated purpose: ___Treatment ___Payment ___Health Care Operations

___Other, please state purpose _____

Records to be disclosed: ___All Records ___Lab ___ER ___Billing ___Operative
___Anesthesia ___PT/OT/ST ___Immunization Records
___Nursing Notes ___Radiology Report ___History/Physical/Discharge

The approximate dates of service to be obtained are: _____

I hereby authorize Rupp Urology Clinic to release and/or obtain information contained in the record of the above named patient as of the date below.

Patient/Personal Representative Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER DATE OF SIGNATURE ON THIS FORM