Sunrise Urology, PC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	Birth Date:
Address:	Phone: Home: Work:

I hereby authorize ***Sunrise Urology, PC*** to

☐ Use and disclose to:

☐ Obtain from:

Name of Facility or Person:	
Address:	Phone:
Via the following method: ☐ Mail ☐ Pick-up ☐ Fax: ( ) -	

Documents Needed:	
☐ Complete record	☐ Hospitalization(s)
☐ All diagnostic test results	☐ Pathology reports(s)
☐ Radiology only	☐ Lab only
☐ Operative report(s)	☐ Other (please specify): ____________________

Purpose of Release:

☐ Continued treatment	☐ Personal Use	☐ Insurance	☐ Legal action	☐ Other ________________

This authorization will expire on the following date, event or condition: __________________________

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

☐ HIV/AIDS	☐ Mental Health	☐ Drug and / or Alcohol Abuse

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on the authorization.

_______________________________ Signature of Patient or Legal Guardian

_______________________________ Date

_______________________________ Printed Name

_______________________________ Person releasing information