Urology Care, PC
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520-298-7200

Release of Medical Information

The following information will assist the office in contacting you with any diagnostic test or procedure results. We will maintain this form in your medical record. It will remain effective until you further notify us of any changes.

I _____, Hereby give consent for my Physician's Office to provide Laboratory, Radiological Testing or Other Imperative Information to:

Please contact me by:

Home: _____ Work: _____ Cell Phone: _____

Spouse: _____ Phone Number: _____

Address: _____

Child: _____ Phone Number: _____

Address: _____

Parent: _____ Phone Number: _____

Address: _____

Other: _____ Phone Number: _____

Address: _____

PLEASE LIST ANY INFORMATION THAT YOU WOULD <u>NOT</u> LIKE RELEASED AND TO WHOM: _____
_____
_____
_____

_____ _____
Patient's Signature Date