IDAHO UROLOGIC INSTITUTE

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www.idurology.com

Authorization for Disclosure of Protected Health Information

_____ _____
(Print name of patient) (Birth date)

_____ _____
(Street address) (City, state, zip code)

_____
(Phone number)

Many times our patients allow family members such as their spouse, parents or others to call and request medical or billing information. If you wish to have your verbal medical or billing information and/or medical records released to family members or others, you must sign the form below.

This authorization is limited to the release of or discussions of the following medical condition(s):

_____
(If no limitations are listed, release of information will be permitted regarding any medical condition for which the patient has received care.)

	Name	Phone Number	Relationship	Include Medical Records	
1.	_____	_____	_____	Yes_____	No_____
2.	_____	_____	_____	Yes_____	No_____
3.	_____	_____	_____	Yes_____	No_____

This authorization is limited to the following timeframe from _____ (date) to _____ (date).
If no dates are indicated, this form will remain in effect for one year from the date of signature.

If at any time I want to revoke this consent, I must notify my Health Care Provider by contacting the Medical Records Department at Idaho Urologic Institute.

Patients Signature: _____ Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name _____

Relationship to Patient: _____