

# Release of Information

I \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Hereby authorize The Center for Men's and Women's Urology, LLC to leave a voicemail or email message at the number or address listed below. I understand that this voicemail or message may contain my protected health information.

Voicemail may be left at this phone number: \_\_\_\_\_

Email may be left at this address: \_\_\_\_\_

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release will not expire unless otherwise specified as follows: \_\_\_\_\_

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient/Date

\_\_\_\_\_  
SSN, Date of Birth, and Other Names Used

\_\_\_\_\_  
Parent, Guardian, or Legal Representative/Date  
(State Your Relationship to the Patient)