UROLOGY

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Please indicate/describe each authorized purpose of the use or disclosure:
[] At the request of the individual (patient)
[] Other

_____

_____

_____

_____

I understand that this authorization will automatically expire in 6 months unless otherwise specified: _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Relationship or Authority of Personal Representative (if applicable)_____

Signature of Legal Representative: _____ Date: _____

Print Name: _____