



AUTHORIZATION FOR RELEASE OF INFORMATION

Copy service is provided by HealthPort, an independent contractor
****Please allow a minimum of 7-10 business days for processing.
There may be a charge for this request. ****

Patient Name _____
(Please Print) First Middle Last

Birth date _____ Social Security Number _____

Information released from:

Clinic Name _____

Provider Name _____

Address _____

City _____ State _____ Zip _____

Information released to: (Fill in either address OR email)

Name _____

Address _____

City _____ State _____ Zip _____

Email (where you would like the records emailed to): _____

Purpose of disclosure _____

Information to be disclosed:

- ALL** - Clinic visit notes, consultations/follow-up visits up to two years.
- Specific** single date(s) of service requested _____.
- X-ray and lab reports
- Pathology reports
- Hospital-operative reports, consultations, ER visits and discharge summaries
- All of the above
- Other _____
- Pathology slides (specifically requested by reviewing physician)

Signature _____

Relationship/reason if other than patient _____

Date _____ (I understand that I may revoke this consent at any time and this authorization is valid for one year unless otherwise noted.)

** I understand that once information is released under this authorization, the clinic, employees and physicians cannot prevent disclosure of information.*

** Information not originally generated by Metro Urology will not be released. Such information must be obtained from the original source.*

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