



METROUROLOGY

AUTHORIZATION FOR RELEASE OF INFORMATION

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:

Name _____

Address _____

City _____ State _____ Zip _____

Purpose of disclosure _____

Information to be disclosed:

- Clinic visit notes, consultations/follow-up visits
- X-ray and lab reports
- Hospital-operative reports, consultations, ER visits and discharge summaries
- All of the above
- Other *(Date(s) of service requested)* _____

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.*

Medical Records Department, Metro Urology
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Fax # 651-297-6115

****Please allow 7-10 business days for processing****