Urology
Center of Idaho

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CONSENT TO RELEASE MEDICAL INFORMATION

Name:____ Date of Birth:_____/_____/________
Last First Middle

List below to whom my health care provider may release/disclose my health information;

Request information to be released FROM:
Name:____
Address:____
Phone:_______________________ Fax__________________

and released TO:
Name:____
Address:____
Phone:_______________________ Fax__________________

Purpose: ☐ Continuing care ☐ Other __________________________________

Information to be released: This authorization permits the above provider to disclose the following medical records:

- ☐ All medical records or from this date _________________________to present.
- ☐ Lab or X-ray reports (ordered by above provider) Date_______________________
- ☐ Pathology reports (ordered by above provider) Date_________________________
- ☐ Other records ____

Term: This Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of ___________, 20______.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____________________________________.

Signature:____ ***Date***: ______________________

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

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