

UROLOGIC CONSULTANTS, P.C.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Full Name _____ Date of Birth _____

Provide all names which you have used while a patient of this practice.

Physician (✓): Anema Bigham Curry Roelof Steinhardt Wise

Records from: UROLOGIC CONSULTANTS, P.C.

 25 MICHIGAN STREET NE, SUITE 3300

 GRAND RAPIDS, MI 49503

Release to: _____

Reason for release:

- Transfer care - Appointment date _____ Insurance
 Consultation - Appointment date _____ Other

Medical information to be sent:

- Entire medical record, **including** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS or AIDS Related complex (ARC).
- Entire medical record, **excluding** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS or AIDS Related complex (ARC).
- Record of care from _____ to _____ **including** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS or AIDS Related complex (ARC).
- Record of care from _____ to _____ **excluding** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS or AIDS Related complex (ARC).

I authorize medical information to be released as indicated above. I understand this release is effective for six months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party. I also acknowledge that future treatment is not conditioned upon execution of the release.

Signature of patient or patient's legal guardian

Date