UROLOGIC CONSULTANTS, P.C.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's 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: ____

____

____

Release to: UROLOGIC CONSULTANTS, P.C.

25 MICHIGAN NE SUITE 3300

GRAND RAPIDS, MI 49503

FAX: 616-459-0044

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