SPRING CREEK UROLOGY SPECIALISTS, LLC

HIPAA MEDICAL INFORMATION RELEASE FORM

Name:_____ DOB:_____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis records, examinations rendered to me, billing and claim information, treatment information, and labs (which may include HIV/STD testing). This information may be released to the following individuals:

NAME/RELATIONSHIP:_____

NAME/RELATIONSHIP:_____

NAME/RELATIONSHIP:_____

NAME/RELATIONSHIP:_____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me writing.

MESSAGES

Preferred Contact telephone number: _____

If unable to reach me:

- You may leave a detailed message with results of labs and/or personal information including financial information such as surgical costs.

- Please leave a message asking for a return call only with no personal detailed personal information.

SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____