

Authorization for Disclosure of Health Information

To fill in a contact person, please complete sections 1 and 3.
To request records, please fill in sections 2 and 3.

- 1) **Emergency Contact/Contact Person:** I authorize Alexandria Urological Associates to disclose my private health information to: _____; relationship to patient is _____.
- 2) **Records Release:** I authorize Alexandria Urological Associates to disclose my private health information to: _____; Relationship to patient is: _____. The records will be picked up, faxed to _____, or mailed to _____

Please list here any specific records you would like disclosed: _____

- 3) I understand this could include information related to AIDS or HIV infection, behavioral health care, and/or treatment for alcohol or drug abuse.

I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on it. Unless otherwise, revoked, it will expire one year from the signature date, to be renewed annually.

Alexandria Urological Associates, its employees, officers, and physicians are released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Patient's Printed Name (first and last)

Date of Birth

Patient's Home Address

Patient's Signature

Date Signed

If signed by person other than patient, please state your relationship to the patient _____ (example is parent, legal guardian, power of attorney or next of kin of deceased) and state if the patient is a minor, incompetent or deceased.