## Corpus Christi Urology Group, PLLC

### AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number:_____

Authorizes CORPUS CHRISTI UROLOGY GROUP,PLLC, to release the following medical information to:

Name of Person (family member, caregiver, etc.)_____

Address: _____

Check all that may be released:

_____**All information _____Diagnosis _____Medications

_____ Lab reports _____X-ray reports _____Care/Treatment plan

_____Operative reports _____Psychological reports _____Other(please specify)

☐ Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

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☐ May we contact you at work and/or leave a message?

____Yes ____No

☐ May we contact you at home and/or leave a message regarding appointments?

____Yes ____No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid.

____Yes ____No

Upon request, a copy of this office's **Notice of Privacy Practices** will be available to you. This notice explains how your medical information will be used and disclosed.

Patient's Signature_____Date:_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____