

# LONESTAR UROLOGY

ROBERT G. STROUD, D.O., F.A.C.O.S.

ADULT & PEDIATRIC UROLOGY

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

### RECORDS REQUESTED FROM:

LONESTAR UROLOGY

DR. ROBERT G. STROUD

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PHONE# (817)335-0199 / FAX# (817) 335-3693

### SEND RECORDS TO:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

I authorize and request the disclosure of protected health information. I specifically authorize release of the following information:

- HISTORY & PHYSICAL EXAM       PROGRESS NOTES       LABORATORY RESULTS  
 RADIOLOGY REPORTS       CONSULTATIONS       ALL HEALTHCARE INFORMATION  
 SPECIFIC HEALTHCARE INFORMATION RELATED TO THE FOLLOWING TREATMENT, CONDITION, OR DATES OF TREATMENT:

\_\_\_\_\_

OTHER: \_\_\_\_\_

This protected health information is disclosed for the following purpose \_\_\_\_\_:

\_\_\_\_\_

I understand the information to be released/disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or drug or alcohol abuse. I authorize the disclosure of this type of information.

I understand that I have the right to revoke this authorization at any time by presenting my written revocation. If this authorization has not been revoked, it will automatically expire one year from the date signed.

I understand that I can refuse to sign this authorization. I need not sign this form to obtain treatment. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules.

\_\_\_\_\_

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE (RELATIONSHIP)

DATE