Authorization for Disclosure of Health Information

Emergency Contact(s)/Contact Person(s): I authorize Alexandria Urological Associates to contact the following person(s) in case of an emergency. Note: this may involve disclosure of private health information.

1. Name: ______________________________
   Phone Number: ______________________________
   Relationship to Patient: ______________________________

2. Name: ______________________________
   Phone Number: ______________________________
   Relationship to Patient: ______________________________

Records Release (circle yes or no): I also authorize Alexandria Urological Associates to disclose all of my private health information to the above person(s).

YES NO

If not all information should be release, please indicate which records are to be disclosed: ______________________________

I understand this could include information related to AIDS or HIV infections, 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 has been taken in reliance on it. Unless otherwise, revoked, it will expire on year from the signature date, to be renewed annually.

Alexandria Urological Associates, it 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): ______________________________

Patient's Home Address: ______________________________
____

Patient's Signature: ______________________________ Date: ____________

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