Kasraeian Urology

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Authorization for the Release of Medical Records:

From: _____

To: _____

Reason for Transfer: _____

Any physician, medical practitioner, hospital, pharmacy, or clinic or other medical or medically-related facility or provider of medical or dental services or supplies.

I authorize you to release and send to Kasraeian Urology a complete copy of any and all of the following information, records or documents related to:

_____ Patients Name (please print)

_____Date of Birth _____ Social Security #

Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my continuity of care.

I understand that the information obtained by use of the authorization will be used for the purpose of continuity of medical care only. Any information obtained will not be released by
Kasraeian Urology to any person or organization EXCEPT to referring physicians who have or will be treating me, or other persons or organizations performing business or legal services in connections with my medical treatment, or as may be otherwise lawfully required, or as I may further authorize.

This authorization is given in connection with continuity of medical care. I intend that it be valid for the duration of my treatment.

A photocopy or facsimile of this authorization shall be valid as the original. I know that I may request to receive a copy of this Authorization.

_____ _____
Signature of Patient, Guardian or Power of Attorney Relationship to Patient (If not signed by patient)

_____
Date of signature