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:

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIPCODE:_____

PHONE:_____ FAX:_____

SEND RECORDS TO:

LONESTAR UROLOGY

DR. ROBERT G. STROUD

1107 UNIVERSITY DRIVE, FORT WORTH, TEXAS 76107

PHONE# (817)335-0199 / FAX# (817) 612-6966

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 If this authorization has not been revoked, it will automatically expire one year from the date signed.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