Fair Oaks Urology

RELEASE OF INFORMATION

I hereby authorize Fair Oaks Urology, LLC to release any information pertaining to my health care, test results, billing and/or accounting information to the following person(s) or agencies.

☐ NO ONE

Authorized Person	Relationship to Patient	Phone Number(s) and/or Email Address

I also authorize the physicians and staff of Fair Oaks Urology to (please reply to all):

1. Leave a message requesting a return call at the following daytime number: (_____) _____ (this is my ☐ cell ☐ home number ☐ work number)

2. Leave a detailed message with the type of test(s) performed, test results and/or any other comments related to my health at: (_____)_____ (this is my ☐ cell ☐ home number ☐ work number)

I understand that this consent will be actively enforced and that if I wish to change the status of this form, I must do so in person and in writing.

_____ _____

Patient or Parent Signature Date

If not the patient, please specify relationship to patient: _____