

**Advanced Urology, Inc.**

**Authorization for Verbal  
Release of Information**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

At times patients may wish to have information regarding their medical condition(s), lab reports, diagnostic test results, medications, appointment dates/times, etc., discussed verbally with other individuals such as a spouse, family member, friend or caregiver in the office or by telephone. Please indicate below any person whom you authorize us to verbally release information to regarding your care at Advanced Urology, Inc.

We will release information to the individual name(s) listed below that you have authorized for the duration of your care at Advanced Urology, Inc. unless you contact us with changes.

**I do not wish to have any medical information discussed with anyone but myself.  
Initial here \_\_\_\_\_**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Effective April, 2003 federal law requires us to offer you a copy of our privacy notice and to obtain your acknowledgment that we offered you a copy. Please tell us if you would like a copy of our privacy notice.

I have been offered a copy of Advanced Urology, Inc.'s Privacy Notice and have completed the Authorization for Verbal Release as indicated.

**Patient Signature** \_\_\_\_\_