KLAIMAN UROLOGY
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Maitland, Florida 32751
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Last Name _____ First Name _____ D.O.B _____

Social Security # (last 4) _____ Maiden/Other Name _____ Phone #_____

Street Address _____City _____State _____ Zip _____

REQUEST RECORDS FROM:

Name of Health Care Facility _____

Address: _____City _____State _____Zip _____

Reason for Disclosure: **CONTINUITY OF CARE AND TREATMENT**

____Recent Labs ____Recent OV ____Radiology Reports ____Operative/Pathology ____Complete Record

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, , and or alcohol/drug abuse and/or AIDS(Acquired Immunodefiency Syndrome) and/or may include the results of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information designated above unless initialized below or otherwise required by law. If I fail to specify an expiration date, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization was retained. I understand that I can receive a signed copy of this form upon request.

RELEASE RECORDS TO:

Name of Health Care Facility _____

Address: _____City _____State _____Zip _____

Reason for Disclosure: _____

_____ _____ _____ _____

Signature Of Patient Date Parent/ Legal Representative Expiration Date

Official Use Only: _____Date: _____Faxed:_____Mailed:_____Given to Patient: _____