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## REQUEST TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize North Carolina Urological Associates to release my Protected Healthcare Information (PHI).  
Please describe the records or types of records you are requesting. **(Be specific in your request.)**

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For period of time from \_\_\_\_\_ to \_\_\_\_\_

Please release the following to:

\_\_\_\_\_  
Physician or Hospital

\_\_\_\_\_  
Address

Full Name of Patient or Legal Guardian: \_\_\_\_\_

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

Address \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

For Office Use Only
Date _____
ID Checked _____

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