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AUTHORIZATION TO RELEASE **MEDICAL INFORMATION**

(Please be advised that our staff cannot speak with anyone that is not listed on this form.
This includes spouses, children and caregivers.)

I am authorizing the personnel at North Carolina Urological Associates to leave medical information, including appointment times and test results, with others if I am not available.

_____ I do not wish to have my information released to anyone besides myself.

OR

_____ I authorize that my information can be left with my spouse/significant other.

Name of person _____

_____ I authorize that my information can be left on my answering machine.

_____ I authorize that my information can be left on my voicemail.

_____ Other: I authorize that my information can be left:

_____/_____
Name Relationship

_____/_____
Name Relationship

Signature: _____ Date: _____

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