Dan Hibbert Urology, PC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

Physician or Facility to provide records: _____

Patient's Name: _____

Social Security Number: _____ Date of Birth: _____

To: **Tooele Urology, PC**
2376 North 400 East Suite 203
Tooele, UT 84074
Phone # 435-882-0071
Fax# 435-882-0073

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of the information of the following condition(s):

Initials:

_____ Drug abuse if any
_____ Substance abuse if any
_____ Psychological or Psychiatric conditions if any
_____ AIDS/HIV if any

Release these records: (please initial)

_____ Only records generated by this facility (not including records received from other sources)
_____ Only some portion of records maintained at facility. Please specify: _____
_____ All medical records at this facility

Expiration or Revocation of authorization: I understand that I may revoke this authorization at any time.
Use of copies: A copy of this authorization may be utilized with the same effectiveness as the original.

_____
Print Patient's Name

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient