PIKES PEAK
UROLOGY

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ADULT AND PEDIATRIC UROLOGY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

☐ Pikes Peak Urology or

☐ _____ Phone/Fax: _____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

The request and authorization applies to:

☐ Healthcare information relating to the following, treatment, condition, or dates:

_____

_____

☐ All healthcare information

☐ Other: _____

_____
Signature of patient or representative Date

This authorization expires 90 days after it is signed.

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