Urology Associates of Norwalk, PC

MEDICAL INFORMATION AUTHORIZATION

Patient name:_____ Date of Birth_____/_____/_____

I authorize the personnel of Urology Associates of Norwalk, PC to release all medical information to my family members and friends listed below.

I may revoke this authorization by phone or in writing at any time.

Name	Relationship to patient	Phone number(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Permission to leave a message on an answering machine or voicemail yes / no

_____ _____

Patient signature Date

_____ _____

Witness signature (office staff) Date