PHOENIX UROLOGY

Name: _____Social Security Number: _____
First MI Last

Date of Birth:_____M ____F ____Marital Status: _____Student: _____

Mailing Address: _____ City:_____

State: _____Zip Code: _____Home Phone: _____Cell Phone: _____

Email Address: _____ Notification Preference: Phone ___ Email___ US Mail___

Employer: _____Occupation:_____

Employer's Address: _____Employer's Phone:_____
City State Zip

Primary Care Physician (PCP):_____Referring Physician:_____

SPOUSE/GUARDIAN INFORMATION:

Relationship to Patient: _____
(It is the policy of Phoenix Urology and Mercury that the parent that requests treatment for the minor child is responsible for all fees)

Name: _____Social Security Number:_____
First MI Last

Date of Birth_____M ____F ____Marital Status: _____Student: _____

Mailing Address: _____ City:_____

State: _____Zip Code: _____Home Phone: _____Cell Phone: _____

Employer: _____Occupation:_____

Employer's Address: _____Employer's Phone: _____
City State Zip

I hearby request this practice to release and disclose the health care information contained in my medical record:
To the following person person(s) or entity:

Name	Relationship	Date of Birth

*I understand that I have the right to terminate this request either verbally or in writing.
*I understand that information used tor disclosed pursuant to this authorization may be disclosed by recipient and may no longer be protected by federal or state law.
*I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient Signature: _____ Date: _____