1207 Hwy 182 W, Suite B Starkville, MS 39759
Telephone: 662-324-1097 Fax: 662-323-8144

Authorization to Release/Obtain Information

I hereby authorize the use or disclosure of my individually identifiable medical health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release of information may be re-disclosed and may no longer be protected by federal privacy regulations.

I, ____, hereby authorize
(Name of Patient)

Starkville Urology; 1207 Hwy 182 W, Suite B Starkville, MS 39759 to release/obtain my medical records to/from:

____
(Name of specific organization with complete address)

For the specific purpose of ____
(Specific reason for the release of information)

I specifically consent only to the release of information or health records pertaining to:

____
(Specific nature and extent of information to be released)

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon ______________________and cannot be renewed with my
(Not to exceed six months)
written consent.

____
Signature of Patient or Legal Representative **Date**

____
Relationship to Patient, if signed by legal representative **Signature of Witness**