

**Corpus Christi Urology Group, PLLC**

**AUTHORIZATION FOR DISCLOSURE OF  
CONFIDENTIAL INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Authorizes CORPUS CHRISTI UROLOGY GROUP, PLLC, to release the following medical information to:

Name of Person (family member, caregiver, etc.) \_\_\_\_\_

Address: \_\_\_\_\_

Check all that may be released:

- \_\_\_\_\_ \*\*All information      \_\_\_\_\_ Diagnosis      \_\_\_\_\_ Medications  
\_\_\_\_\_ Lab reports      \_\_\_\_\_ X-ray reports      \_\_\_\_\_ Care/Treatment plan  
\_\_\_\_\_ Operative reports      \_\_\_\_\_ Psychological reports      \_\_\_\_\_ Other (please specify)

Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

\_\_\_\_\_  
 May we contact you at work and/or leave a message?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

May we contact you at home and/or leave a message regarding appointments?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid.  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: \_\_\_\_\_ Date: \_\_\_\_\_