

Mid Atlantic Urology Associates, LLC.

Permission to Release Medical Information

Patient: Required by Federal Law

I, _____ hereby give permission to Mid Atlantic Urology Associates, LLC., its employees, and sub-contractors to release current, past and future information about my medical condition, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six , *(in italics)*, that are required for us to care for you)

- *My present and future health insurers*
- *My referring or primary health care provider*
- *Other health care providers caring for me*
- *Health care providers/laboratories I am referred to*
- *Health care facilities I am referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- My spouse or significant other _____
- My parents _____
- My employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand Mid Atlantic Urology Associates ,LLC.will make reasonable efforts to insure my privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____

Guardian for Dependant:

I, _____ hereby give permission to Mid Atlantic Urology Associates , LLC its employees, and sub-contractors to release current, past and future information about _____'s, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six , *(in italics)*, that are required for us to care for you)

- *His/her present and future health insurers*
- *His/her referring or primary health care provider*
- *Other health care providers caring for him/her.*
- *Health care providers/laboratories he/she is referred to*
- *Health care facilities he/she is referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- His/her spouse or significant other _____
- His/her parents _____
- His/her employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand that Mid Atlantic Urology Associates ,LLC PA will make reasonable efforts to insure his/her privacy but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____