## CHILDREN'S UROLOGY OF THE CAROLINAS

Please forward the records regarding:

Last Name _____ First Name _____ Middle Name _____

Mailing Address

_____

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____

From:_____

_____

_____

To: Children's Urology of the Carolinas

230 Baldwin Ave Charlotte, NC 28204

704-376-5636 (Phone) 704-376-5933 (Fax)

This information shall include all records unless specified otherwise. This authorization is for a Full Disclosure, including clinical findings, diagnosis, treatment, assessment, recommendations for future care, names of health care personnel, dates of hospitalizations and ambulatory visits, and any information that may be related to a drug, alcohol, psychiatric condition(s), and /or any sexual transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.

Date range: _____ to_____
Medical Exclusions:_____
Purpose for Disclosure: _____

I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for one year from the date of signature. I understand that may cancel this request with written notification but that it will not have any effect on information released prior to notification of cancellation.

Signature of Parent/Patient/Legal Authority:_____

Print Name:_____

Date:_____