GRU Urology

Medical Office Building, 1120 Fifteenth Street
Suite BP 4161 (4th Floor), Augusta, GA 30912
Adult Appointments/Referrals: 706-721-3042

Release of Protected Health Information

Patient Name_______________________________________ Birth date _____/_____/_____

Social Security #________________ *(optional)*

Phone numbers (Home)_____________________ (Work)_________________ (Other)_____________________

1. Please release my records from:

Clinic or facility:____

Address:____ City:_______________________________

State:______________ Zip code:______________ Phone:____________________ Fax:____________________

2. Please release my records to:

Section of Urology
1120 Fifteenth Street, Suite BP 8414
Augusta, GA 30912
Phone: (706) 721-9977
Fax: (706) 721-2548

Attn: ____

3. Specific Information Requested:

- ☐ Discharge summary
- ☐ History and physical exam
- ☐ Consultation reports
- ☐ Outpatient clinic notes
- ☐ Pathology reports
- ☐ Lab reports
  Specify: ____
- ☐ X-ray / Radiology reports
- ☐ Films / CDs
  Specify:____
- ☐ Operative reports
- ☐ EKG/ECHO reports
- ☐ Cardiology Clearance for surgery
- ☐ Pathology slides / tissue blocks
  Specify:____
- ☐ Other: ____

I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from the GRU Cancer Center.

Signature of Patient or Representative:

X____ Date: ___________________

Relationship to Student (*if signer is not the patient)*:

☐Parent ☐Legal Guardian ☐Other: ____