RELEASE OF MEDICAL INFORMATION TO A THIRD PARTY

PATIENT NAME	DATE OF BIRTH

In connection with the medical services that I am receiving, I hereby authorize *West Coast Urology* and their respective agents to disclose any and all information concerning my medical condition and treatment (including but not limited to super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence or other such information), including copies of applicable hospital and medical records to:

A. Any third party payor covering the medical services of the patient;

B. Other health care professionals and institutions involved in the delivery of health care to patient;

C. The proponent of any legally sufficient subpoena, or in response to a court order;

D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;

E. Pharmacies;

F. As otherwise required by law.

When providing information to me, information may be transmitted to me by any or all of the following means *(initial all that apply)*:

_______ Telephone messages on an answering machine

_______ Messages to the following family members or friends: Please list name and relationship.

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_______ E-mail to the following address ____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place restrictions upon the consent hereby given:

This consent is valid from the date executed until revoked in writing by the patient.

SIGNATURE	TODAY'S DATE
X	