MEDICAL RELEASE OF INFORMATION

Patient Name: ____ Date of Birth: _____/____/_____

This is Form intended as a Release of healthcare Information to:

Texas Prostate Institute

FAX: 713-575-3688

[ ] I _________________________________ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me.

Should you have any questions, Please call my: [ ] my home [ ] my work [ ] my cell
Number:__________________________ Alternate number:______________________________

If unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] The best time to reach me is (day) ____________________ between (time)___________

Patient signature:

____

Date: ____/____/_____ Time: ________AM/PM

Special Instructions/Request:

____
____
____