



Southeast Valley Urology
 A Division of Ironwood Physicians, PC
 Ironwood Radiology
 Ironwood Cancer & Research Centers
Consent to Release Health Information

Patient Name: _____

Date: _____

I hereby authorize Ironwood Cancer & Research Ctrs and Urology Associates to use and disclose my personal health information to the individuals identified on this form.

Initials

I approve and understand that the staff at Ironwood may leave detailed messages on my voicemail.

Initials

Contact Name: _____ () _____

Address: _____
Last First M.I. Telephone

_____ City State Zip
 Spouse Family (Describe) _____ Friend Other (Describe) _____ Emergency Contact? Yes

Contact Name: _____ () _____

Address: _____
Last First M.I. Telephone

_____ City State Zip
 Spouse Family (Describe) _____ Friend Other (Describe) _____ Emergency Contact? Yes

Contact Name: _____ () _____

Address: _____
Last First M.I. Telephone

_____ City State Zip
 Spouse Family (Describe) _____ Friend Other (Describe) _____ Emergency Contact? Yes

1. I hereby authorize Ironwood Cancer & Research Ctrs and Urology Associates to use and disclose my personal health information to the individuals identified on this form.
2. I understand this may include information relating to communicable diseases, such as HIV/AIDS, STD, behavioral, and/or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
3. I understand that the individuals identified on this form will be treated by Ironwood Cancer & Research Ctrs and Urology Associates as individuals involved directly in my care and as such Ironwood Cancer & Research Ctrs and Urology Associates will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Ctrs and Urology Associates.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Cancer & Research Ctrs and Urology Associates will not be affected if I refuse to sign this authorization.

 Patient Signature

 Date/Time AM or PM (circle one)

Personal Representative Signature

Relationship

Date/Time

AM or PM (*circle one*)