PENINSULA UROLOGY CENTER, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

DOB _____

I hereby authorize Dieter Bruno, M.D., F.A.C.S., to furnish medical information concerning (patient) to

_____

_____

(name and address of person to receive records).

_____ **I Agree that** any and all information may be released, including but not limited to mental health records protected by the Lanterman-Pertris-Short Act, drug and/or alcohol abuse records and/or HIV test results, and/or any dictation or medication documentation contained in the patient's medical chart.
Initials

_____ **I do not Agree that**
Initials

The information requested should be used for the following:*_____

_____

_____

_____

**IMPORTANT there is a standard $10.00 Flat Fee for the printing and release of your records.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____ DOB _____

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary of personal representative of deceased patient **
[ ] spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*Signed: [redacted] Dated:
Treating Physician

For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both patients's treating physician and the patient sign the authorization form before information may be released.

***It is unclear whether the beneficiary of personal representative of a deceased patient can obtain and disclose records containing HIV test results.*