Urological Specialists of Virginia

Authorization for Release of Confidential Health Care Information

Patient Name:	Date of Birth:	
Street Address:		
City	State	Zip

This authorizes Urological Specialists of Virginia to request and receive
Prescriber's Name

from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient name above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature:	Date:
Guardian Signature:	Date:

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.