DuPage Urology Associates, Ltd.
Consent for Release of Confidential Information

I, ________________________________, hereby give my consent to
(print)
DuPage Urology Associates, Ltd. and/or physician or physician's staff to give or leave medical information as follows below. **Please check all applicable selections:**

You may leave medical information for me at the numbers listed below:

________________	________________	________________	__________	__________
home phone	work phone	mobile phone	direct only	direct & voice mail

You may leave medical information with the person(s) listed below:

____________	____________	____________	____________	________	________
name	relationship	phone #1	phone #2	direct only	direct & voice mail

____________	____________	____________	____________	________	________
name	relationship	phone #1	phone #2	direct only	direct & voice mail

____________	____________	____________	____________	________	________
name	relationship	phone #1	phone #2	direct only	direct & voice mail

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to do so to the physician or physician's office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Signature of patient / guardian ____________________ Date: ___________

Signature of witness: ____________________ Date: ___________