



# Hunterdon Healthcare

Your full circle of care.

Hunterdon Urological Associates

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## Permission to Share Medical Information

This signed form allows Hunterdon Urological Associates to give information (medical or billing) to the person you list on this form on your behalf. You may remove this authority at any time in writing.

I, \_\_\_\_\_, \_\_\_\_\_

**Patient's Name**

**Date of Birth**

I give permission to Hunterdon Urological Associates to leave detailed messages at the following telephone number: \_\_\_\_\_.

I give permission to share my medical (ie: labs, radiology, office notes) and financial information (ie: billing inquiries, problems) about this visit and all future visits to:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

*I may remove this permission on written notice.*

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date