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RELEASE OF INFORMATION CONSENT

Account Number: _____

I, _____ give Urology Specialists of the Carolinas permission to release the following information to the party(s) listed below.

I acknowledge that I have the right to revoke this consent at any time.

Authorized person(s):

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>

Can we leave a detailed message on your voicemail/answering machine?

(please circle)

Home phone # _____ Yes No

Work phone # _____ Yes No

Cell phone # _____ Yes No

Patient signature: _____ Date: _____

Witness: _____ Date: _____

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