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**Authorization To Disclose Medical Information**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I am the \_\_\_ Patient \_\_\_ Guardian \_\_\_ Designee and hereby authorize

Dr. \_\_\_\_\_ of South County Urological Inc; to disclose medical information to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Purpose of Disclose: \_\_\_\_\_

Dates of Service to be released: \_\_\_\_\_

Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of all health care personnel, dates of hospitalizations, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease including AIDS information.

Exclusions (please initial) Drug/Alcohol \_\_\_\_, Mental Health/Psychiatric \_\_\_\_, Sexually Transmitted Disease \_\_\_\_, HIV/AIDS \_\_\_\_.

I understand that records received by South County Urological from another physician can not be released.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. This authorization will expire 90 days from the date signed unless otherwise revoked or specified. I also understand that this consent is only for the specific purpose stated above.

South County Urological, Inc.; its employees and physicians are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_

If patient is a minor, I certify that I am the patient's legal custodisn and that I have full authority to consent to the release of medical information. If the patient is incompetent, deceased, I certify that I am authorized to consent to the release of medical information.

Signature of Parent and/or Authorized Representative: \_\_\_\_\_

**NOTE: Response time is TWO WEEKS. If you need these records for an upcoming appointment, please specify the date : \_\_\_\_\_**