Patient Communication Consent Form

Patient Name (Last, First, Middle Initial):______________________________________

Date of Birth:_________________

I authorize The Urology Center of Southern California and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

Name	Relationship to Patient	Contact Information

By my signature below, I acknowledge that I have read and understand the information provided on this consent form.

Patient Name:____

Patient Signature:_______________________________________ Date:______________