



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.

<u>Name</u>	<u>Relationship to Patient</u>	<u>Contact Information</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Patient Name: _____

Patient Signature: _____ Date: _____