Effingham Urology Associates S.C.
414 W. Virginia Ave.
P.O. Box 1169
Effingham IL 62401
Phone (217) 342-9738 Fax (217)342-9806

Patient Name _____

Address _____

Date of Birth _____

Permission is hereby granted for release of all medical information

From: _____

_____

To: _____

_____

Initial All Below:

_____ I am aware there is a fee to copy/send/fax medical records.

_____ I consent to release of all medical information.

_____ I do specifically consent to transmission of my medical records via a fax machine.

_____ I recognize that the information disclosed may contain drug/alcohol and/or mental health information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ I recognize that the information disclosed may contain information regarding sexually transmitted disease or HIV/AIDS testing information. I specifically consent to disclosure of such information.

Signature: _____ **Date:** _____