I, , authorize Urology P.C./Urology Surgical Center to fax the listed documentation to the following fax number and business per my request.

Print Name

Fax #: Business:

I understand I have asked to have this fax sent to what may not be a secure fax.

Documentation: (circle one)

Work Release School Release FMLA Forms Other:

Patient Name:

Print Name

Patient DOB:

Signed by: (circle one)

Patient Parent POA

Signature: Date: