

UROLOGY ASSOCIATES

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RELEASE OF INFORMATION:

I hereby authorize Urology Associates to furnish medical or other information concerning my present illness or injury to my family physician(s), Medicare, insurance companies, employers or their representatives.

I further authorize my family physician(s), referring physician(s), and other care providers to furnish all medical information concerning my present illness or injury to Urology Associates. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF AN ORIGINAL.

I further authorize Urology Associates to leave appointment reminders and general INITIALS information on my home and/or business answering machine.

ASSIGNMENT OF BENEFITS:

I further request payment of the Surgical and / or Medical Benefits, otherwise payable to me, directly to Urology Associates for services provided. I understand that I am financially responsible to Urology Associates for charges not covered by this Assignment of Benefits, except when Medicare requires certain services be assigned only.

*****Due to the large volume of lab work and tests, which are obtained daily, we will attempt to contact you with your lab values. However, ultimately you are responsible for calling our office for laboratory results.***

Patient's Signature Date

Responsible Party / Date
Parent / Guardian

I hereby acknowledge that I have been presented with a copy of Urology Associates' Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____