

Urology Group, PA

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Patient Authorization Form

↓ To Be Completed By Urology Group, PA Personnel ↓

Patient Name

Date of Birth

Street Address

Date of Service

City, State, Zip Code

Accession #

Phone Number

Type of Specimen

↓ To Be Completed By Patient ↓

Date: _____

I, _____, hereby authorize the release of the slides of my case to the following facility or doctor:

Doctor: _____

Address: _____

Building/Suite: _____

City/State/Zip: _____

Phone: _____

Date of Appt.: _____

Signed: _____

Patient's Name

Approval: _____

M.D. Signature