

I, _____, authorize Nebraska Urology/Urology Surgical Center
Print Name
to fax the listed documentation to the following fax number and business per my request.

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: _____