

**UROLOGY SPECIALISTS
AUTHORIZATION FOR THE USE OR DISCLOSURE
OF HEALTH INFORMATION**

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/State/Zip: _____
Maiden/Previous Name/Nickname: _____
Social Security Number: _____

Provider (who is releasing information?):

Provider/Facility Name: _____
Address: _____ Phone: _____
City/State/Zip: _____ Fax: _____

Disclose Information to (Where is the information to be sent?):

Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Release the following information with dates from _____ to _____ :

Entire Record Clinic Progress Notes Surgery Notes Pathology Reports
 Lab Reports X-ray Reports Other: _____

I authorize the request for the release of these records for the purpose of (be specific):

Continued Health Care Consult/Second Opinion Out of town move
 Insurance Claim Legal Personal
 Other (Specify): _____

- I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand I have a right to revoke this authorization at any time. I must do so in writing to the Privacy Officer at Urology Specialists. If I fail to specify an expiration date this authorization will expire in 12 months from the date of signature. Expiration date: _____.
- I understand that authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions I can contact the Privacy Officer for Urology Specialists.
- Signature of patient is required for all patients 18 years of age or older. A parent or legal guardian may provide an authorizing signature if the patient is a minor, or if the patient is physically or mentally incompetent.
- I understand there are fees for copying medical records except when for continuation of care. I also understand I need to allow at least one week for the records to be released after payment for copies has been received.

Signature of patient/representative

Signature Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness

For office use only:

Date sent: _____

Sent by: _____

CHART NUMBER: _____