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 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 disease, 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 12 months from date of signature. Expiration date: _____.
- I understand that authorizing the disclosure of this 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 of 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 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: _____