UROLOGY SPECIALISTS AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED 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: _____ Phone: _____
City/State/Zip: _____ 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 ____Work Comp
____Insurance Claim ____Legal ____Personal/Out of town move
____Other (Specify): _____

Release Format (Check only 1 option):
____ Paper via ____Mail **OR** ____Pickup **OR** ____Fax #: _____
____Electronic - Allow Associated Account Holder Access via My Patient Portal

- 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 30 days 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 (If applicable)

For office use only:
CHART NUMBER: _____