The Center For Men's and Women's Urology

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Authorization to Disclose Protected Health Information

COMPLETE ALL AREAS OF THIS FORM AND SEND TO THE APPROPRIATE HEALTH CARE PROVIDER

PATIENT:		
NICKNAME/MAIDEN NAME/OTHER:		
DATE OF BIRTH (MO/DAY/YR):	TELEPHONE NUMBER:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:

I authorize (Name of health care provider/clinic): _____

_____

(Address): _____

_____

(Phone): _____ to release the following information for the purpose of continuing health care.

Please forward the information described below to: _____
(Name of health care provider/clinic where records are to be sent)

☐ Records related to (Describe dates, conditions, etc.): _____

☐ All imaging reports (Describe dates, conditions, etc.): _____

☐ Other (Describe dates, conditions, etc.): _____

Please send my protected health information to: _____
(Address/Phone/Fax of health care provider/clinic where records are to be sent)

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information.

☐	Mental Health Information	☐	Genetic Testing Information
☐	HIV/AIDS Information	☐	Drug/Alcohol Diagnosis, Treatment, or Referral Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law, However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. I have read this authorization and understand it. Unless revoked, this authorization expires in 24 months or shall remain in effect for a period of time reasonable needed to effect the purpose for which it was gained.

---- SIGNATURE(S) AND DATE REQUIRED BEFORE PROCESSING ----

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL DATE

_____

IF THE ABOVE SIGNATURE IS NOT THAT OF THE PATIENT, PRINT NAME AND DESCRIBE AUTHORITY TO RE RESENT THE PATIENT