UROLOGIC

Authorization for Release of Information

Patient Name _____

Patient DOB _____

For information about how your medical information may be used or disclosed, please see our Notice of Privacy Practices. You have the right to review the Notice before you sign this form. This Notice is subject to change. The Notice is also posted at Urologic's office.

- YOU HAVE THE RIGHT TO INSPECT, COPY, AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED. THERE IS A $1.00 PER PAGE FEE FOR COPIES.
- YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.
- WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

I do hereby authorize _____ to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to which I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan or health care provider the released information may be disclosed and that my health information may no longer be protected by federal privacy regulations. I understand there might be a cost for copies of the information.

_____ Complete medical record that may contain treatment notes regarding radiology, pathology, procedure(s), and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

OR

For information collected/services described below and provided during the time period of _____,

Description of records to be released: _____

To the following: _____

For the purpose(s) of: _____

I understand that I may withdraw my authorization in writing to the Privacy Officer at any time except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire one (1) year from this date. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patients representative Date

Printed name of patient's representative_____

Description of representative's authority to act for the patient _____

Relationship to the patient _____