South County Urological, Inc

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ Date of Birth: _______________________

I authorize the use or disclosure of the above named individual's health information as described below.

INFORMATION TO BE RELEASED BY:

____

Organization/Person Name

____

Address City, State, Zip

INFORMATION TO BE RELEASE TO:

____

Organization/Person Name

________________________________ Fax__________________

Address City, State, Zip

TYPE OF MEDICAL INFORMATION TO BE USED OR DISCLOSED

__Complete Medical Record
__EKG
__Problem List
__Consultation Reports
__List of Allergies
__X-Ray Reports
__Lab Reports
__Other (please specify) _____________________
__Immunization Records
__Physician Progress Notes
__Medication List

Specific date range: ___________________________________

THE PURPOSE FOR WHICH I AM AUTHORIZING THIS USE OR DISCLOSURE IS:

__At the request of the Individual
__Military
__Insurance Application
__Other_________________
__Legal Purposes
__Personal Use
__Social Security/Disability Determination
__School
__Insurance Claim

This authorization shall be valid-unless I revoke it earlier in writing – until:

___One year from the date I sign this authorization
___The following date________________________________
When the following event occurs ____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded here ___________________________________

I understand

1) I may revoke this authorization at any time by giving South County Urological, Inc. notice of my revocation in writing. South County Urological, Inc. will furnish me with a form to make my revocation but I do not have to use that form to make my written revocation.
2) My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give South County Urological, Inc. written notice of my revocation.
3) South County Urological, Inc. may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4)Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.

Signature and Date

I (or my Personal Representative on my behalf) have signed this Authorization voluntarily on the date written at the top of the first page. I have read and understand the content of this Authorization for Use or Disclosure Protected Health Information, direct that it be in effect and followed beginning on the date written at the top of the first page until it expires or is revoked and I have been given a signed copy.

Signature (Individual/Person Representative/Guardian)____

Relationship of Signature if not self ____

*******For Office Use Only*******

South County Urological, Inc. Verification

___Identity of the Individual verified or ____ Identity, Authority to Act of Personal Representative/Guardian verified

By: _________________________________ _________________________________

Signature Printed Name and Title