Urology Associates

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize _____
_____

To release information from my records to:

[ ] Urology Associates of Mobile, P.A.
168 Mobile Infirmary Boulevard
Mobile, Alabama 36607
PH (251) 433-1895 FAX (251) 433-1917

[ ] Urology Associates of Mobile, P.A.
6701 Airport Boulevard, Suite B135
Mobile, Alabama 36608
PH (251) 433-1895 FAX (251) 433-1917

[ ] Urology Associates of Foley, P.A.
1506 N McKenzie Street
Foley, Alabama 36535
PH (251) 433-1895 FAX (251) 433-1917

[ ] Urology Associates of Fairhope, P.A.
8720 Fairhope Avenue
Fairhope, Alabama 36532
PH (251) 433-1895 FAX (251) 433-1917

[ ] Urology Associates of South MS, P.A.
1153 Ocean Springs Road
Ocean Springs, Mississippi 39564
PH (228) 819-8586 FAX (251) 433-1917

The purpose or need for this release of information is: _____
_____

The Specific information to be disclosed is:

[ ] Physician's chart notes
[ ] X-Ray reports
[ ] Ultrasound report
[ ] Pathology Reports
[ ] Other _____
[ ] Operative Reports
[ ] Urological related records
[ ] Financial records
[ ] CT Scan

Information which may not be disclosed:_____

Note: Special dates of interest: _____ to _____

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders of mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

Urology Associates

Authorization for Use and Disclosure of Protected Health Information

Authorization must be signed by the patient, or patient's legal representative.

Patient Name: _____SSN: _____

Address: _____ Date of Birth: _____

I understand this authorization will expire one year from the date signed unless otherwise specified:

_____
Expiration Date

_____ _____
Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am: _____

_____ _____
Witness Date