



**Authorization for Use and Disclosure of Protected Health Information**

I hereby authorize Urology Associates of Mobile, P.A., to release information from my records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

The purpose or need for this release of information is: \_\_\_\_\_

The specific information to be disclosed is:

Physician's chart notes

Operative Notes

CT and X-ray reports

Urological related records

Ultrasound report

Financial records

Pathology reports

CT Scan

Other \_\_\_\_\_

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 Urology Associates or its' staff has taken action 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 or 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 Urology Associates to use or disclose 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.

**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

