AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the Urology Center of Florida to use or disclose my protected health information as indicated below:

PATIENT INFORMATION

Last Name	First	MI
Date of Birth	Social Security Number	
Address		
City	State	Zip
Daytime Phone Number ( )	Evening Phone Number ( )	

RECORD HOLDER			RECORDS MAY BE RELEASED TO		
Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone ( )	Fax ( )		Phone ( )	Fax ( )	

INFORMATION TO BE RELEASED

DATES OF SERVICE	☐ All ☐ From ____/____/____ To ____/____/____			
TYPES OF INFORMATION	☐ All ☐ History & Physical ☐ Progress Notes	☐ Consultation Reports ☐ Laboratory Reports ☐ Pathology Reports	☐ Radiology Reports ☐ Op/Procedure Reports ☐ Discharge Summary	☐ Other
USE OF INFORMATION	☐ Continuing Care ☐ Legal	☐ Second Opinion ☐ School	☐ Personal ☐ Insurance	☐ Other

SPECIAL CATEGORIES OF INFORMATION

YOU MUST SPECIFICALLY AUTHORIZE THE DISCLOSURE OF THE FOLLOWING TYPES OF INFORMATION. (PLEASE CHECK ALL THAT APPLY)

☐ HIV Testing Results/AIDS Information	☐ Alcohol and/or Drug Abuse Treatment	☐ Psychiatric/Mental Health Records	☐ Sexually Transmissible Diseases

X	
Signature Patient/Legal Guardian/Authorized Person	Date of Signature

I UNDERSTAND THAT:

1.	This authorization may be revoked in writing at any time, according to the instructions in the Urology Center of Florida Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization is valid for one year from the date signed below.** A photocopy of this form will be considered as valid as the original.
2.	Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal regulations.
3.	I am under no obligation to sign this authorization. My health care and payment for my health care will not be conditioned on signing this authorization.
4.	I may inspect and obtain a copy of any information disclosed. I may be charged a fee of up to $1.00 per page for every page copied.
5.	I will get a copy of this form after I sign it.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATIUON.

X	
Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature
Patient/Legal Guardian/Authorized Person (Printed Name)	Relationship If Other Than Patient
X	
Witness (Signature)	Date of Signature