Urologic Associates of Western Pennsylvania

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize_____ to release information from the record of_____

DOB_____SS#_____.

To: Name of Facility/Person_____Address_____

Phone_____ Fax_____

Records to be released are: (Please check all that apply)

_____Physician Written Records ___Lab Work/Test results (ordered by physician in the Practice)

Records are requested for the purpose of (Please provide detailed description)

HIV, Behavorial Health and Drug and Alcohol Information contained in the parts of the record indicated above will be released through this authorization unless otherwise indicated. Do not release:

HIV___ Behaviorial Health (Psychiatric)___ Drug & Alcohol___

I understand the following:

*That my health record(s) will not be released or obtained by Urologic Associates of Western, PA unless permission if provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).

*That the release of my health record(s) will be for the purpose stated on this form, and only those items indicated will be released.

*That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.

*That this authorization is in effect for a period of 90 days from the date of the signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.

*That I have the right to revoke this Authorization form at any time by sending a written request to the entity where the authorization was provided.

*That my decision to revoke the Authorization does not apply to any releases of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

*That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.

*That I am entitled to a copy of the signed Authorization form.

Patient Signature_____Date_____

Legal Representative Signature_____Date_____

The above named patient is unable to provide a signature due to:_____

Relationship to patient and description of authority to act on behalf of patient _____