

**Authorization for the Release of Information  
(Federal Privacy Regulations (HIPAA))**

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I voluntarily authorize the use of disclosure of my individually identifiable health information as described below:

My current health insurance carrier (yes or no): \_\_\_\_\_

My primary physician (only if named): \_\_\_\_\_

Any other individual: (name): \_\_\_\_\_

**Specific description of information:** All personal health information and identifiers including but not limited to name, address, telephone number, social security number, health plan number, date of birth, dates relating to medical treatment including diagnosis, prognosis, treatment, and procedures generated or collected during the course of treatment; and past medical history/procedures released and received from others.

**Persons providing the information:** Doctor and staff; hospital and clinic records.

**Persons receiving the information:** Those specified on the lines above.

I may revoke (stop) this authorization at any time by written notice to Dr. \_\_\_\_\_  
at Urologic Physicians, P.A.

If I do revoke my authorization, any information previously given out cannot be withdrawn or taken back.

Once information about me is given out in accordance with this authorization, the person(s) and/or organizations may give it out to others and the information may no longer be protected by federal privacy regulations.

Your medical records may be held and processed on computers.

I may refuse to sign this authorization form. If I choose not to sign this form, I am the only person who may speak with my physician, his nurse, business office or scheduling staff. All correspondence will be directed to myself at the address I have provided in my chart. If I refuse to sign, my medical care will not be affected.

This authorization will have no expiration date unless I revoke it.

I will be given a copy of this authorization form.

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient

**You may refuse to sign this authorization**