Authorization for Use or Disclosure of Protected Health Information

For Release of Medical Records

Please complete the following information:

Patient Name: _____ Date of Birth _____

Address: _____ SSN: _____

_____ Phone: _____

These Records are needed for an appointment on: _____/_____/_____

I authorize Uropartners, LLC to release/disclose the following information to _____for the above patient:

☐ All Records ☐ Laboratory/Pathology Records ☐ X-ray/Radiology Records

☐ Billing/Financial Records ☐ Other (describe specifically)_____

Dates of Treatment being disclosed: From: _____ To: _____

Copied Medical records are to be sent to:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

The information may be used/disclosed for each of the following purpose:

☐ At my request (only the patient can check this box) ☐ For employment purposes

☐ For my health care ☐ For payment/insurance ☐ Other: _____

This authorization shall expire no later than: _____/_____/_____ and may not be valid for greater than one year from the date of signature below for the release of medical records to the above named company/person.

I understand that with signing this release, I am allowing Uropartners, LLC to disclose my health information, which may include: HIV/AIDS status, cancer diagnosis and treatment, drug/alcohol abuse, or sexually transmitted diseases. I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refuse to sign will not affect my ability to obtain treatment from Uropartners, LLC. By signing below, I am authorizing the use or disclosure of protected health information and that a fee will be assessed for photocopying and shipping.

_____ _____

Signature of patient or legal guardian Date

_____ _____

Printed name of patient or legal guardian Relationship to patient

Release Date: _____/_____/_____ #Pgs:_____ Certified: Y N Via: Mail Fax Pick-up Completed by Initials:_____

Fee Assessed for Photocopies: $_____ Paid by: Cash Check Credit Card