ADVANCED UROLOGY INSTITUTE

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used or disclosed
The information covered by the authorization includes:

_____

_____

Purpose for disclosure:_____

Records requested from:

Dr. _____

Address:_____

Phone #:_____ Fax #:_____

Records to be sent to:

Dr. _____

Address:_____

Phone #:_____ Fax #:_____

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Advanced Urology Institute HIPAA Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of Patient (Print or Type) DOB/Social Security #

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship of Patient Representative to Patient

_____
Witness Person Completing Request Date Sent