Authorization for Use or Disclosure of Protected Health Information

This form allows us disclose your health information to family members/friends, physicians, and/or organizations you would like involved in your care.

Patient Name: ___________________________________ **Date of Birth:_____________________________________**

I request and authorize **Northwest Urology, LLC** to release protected healthcare information of the above named patient to:

____

Name of Individual and/or Organization   Relationship to patient   Phone   Fax

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Name of Individual and/or Organization   Relationship to patient   Phone   Fax

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Name of Individual and/or Organization   Relationship to patient   Phone   Fax

Information to be used or disclosed:

- ☐ **Entire Medical Record**
- ☐ Pertinent Records (last 2 years)
- ☐ Radiology Report(s)
- ☐ Laboratory/Pathology Report(s)
- ☐ Other______________________________________

SPECIALLY PROTECTED RECORDS

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that the information below will be disclosed if I place my **initials** in the applicable space next to the type of information.

_______ HIV/AIDS Information   _______ Mental Health Information

_______ Genetic Testing Information   _______ Drug/Alcohol Diagnosis, treatment, or referral information

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Note: Unless revoked, this authorization will expire one year from date of signing.

____   ____

Patient/Legal Guardian Signature   Date

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Printed Name