the Urology clinic
your care specialists

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Suite 1
Bristol, TN 37620
423-844-6600
Fax: 423-968-1255

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Records are to be: Mailed Faxed **Date needed:** _____

I hereby authorize _____ to release my individually identifiable health information as described below to the following individual or entity. I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations.

Address, phone and fax numbers of person or organization authorized to receive the information:

_____

_____

_____

Information to be disclosed: Entire Record Office Notes Operative notes

Lab reports Radiology reports Pathology reports Other: _____

Information will be used or disclosed for the following purpose:

At request of the individual At physicians request to assist in the provision of service or treatment

Other: _____

Covering the period of healthcare: From: _____ to _____

I understand that I may revoke this authorization at any time by notifying THE UROLOGY CLINIC in writing, except to the except that (a) action has already been taken in reliance on this authorization or (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Authorization expires one year from date executed unless otherwise specified.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal will not affect my eligibility for benefits, payment for coverage of services, or ability to obtain treatment.

The Urology Clinic, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorized herein.

Signature: _____ Date: _____

Person completing request: _____ Completed Date: _____