Urology of Indiana

Authorization to Use and Release Protected Health Information (Release **from** Urology of Indiana)

I, _____ who resides at _____ in the city of _____ in the state of _____ hereby authorize Urology of Indiana, LLC to discolose the following medical information by: ☐ Mail ☐ Fax

To:

Name: _____

Address: _____

City, State, Zip: _____

The purpose of this release is: _____

_____

My authorization extends only to those data elements/documents indicated below:

- ☐ Statements of charges or payments
- ☐ Records of visits (all visits)
- ☐ Record of visit for a specific date or dates. Specific dates included are limited to:
- ☐ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.) _____
- ☐ All of the above
- ☐ Other, Specify: _____
- ☐ Mental Health and/or alcohol and drug abuse treatment
- ☐ HIV Information
- ☐ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. That a photocopy or fax of this authorization is as valid as this original.
3. That a potential exists for information I authorize to be re-disclosed by the recipient.
4. That I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty-day (60) period from the date it is signed, or sooner if noted below.

_____ _____

Patient Signature, or Patient's Legal Representative, or patient's parent or Guardian if under 18

Social Security Number

_____ _____

Patient's Name, Printed

Date

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