Urology of Indiana

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

I, _____who resides at _____ in the city of _____ in the state of _____ hereby authorize

Name: _____

Address: _____

City, State, Zip: _____

to disclose the following specific medical information to Urology of Indiana, LLC by:

- ☐ Mail : 679 East County Line Road Greenwood, Indiana 46143
- ☐ Fax : 317-807-0140

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