



# 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 disclose 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 re-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