

CENTER FOR UROLOGICAL SERVICES, P.C.

4545 E CHANDLER BLVD #300

PHOENIX AZ 85048

PH: (480)961-2323

FAX: (480)961-2325

TO: _____

RE: _____ DOB: _____

Print Patient Name

By signing this authorization, I authorize the above person(s)/facility to use and/or disclose certain protected health information (PHI) about me to **Center for Urological Service, PC**. This authorization permits the above person(s)/facility to use and/or disclose the following individually identifiable health information about me:

_____ Complete Summary of urological records

_____ Xray film reports

_____ Lab reports

_____ Copy of EKG's

_____ Other: _____

This authorization includes release of information concerning communicable diseases.

The information will be used or disclosed for the following purpose:

_____ continuing medical treatment

_____ other: _____

If requested by the patient, purpose may be listed as "at the request of the individual".

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from date of signature or _____ (whichever is earlier).

The Practice will not receive payment or other remuneration from any third party or the patient in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Center for Urological Services, PC. In fact, I have the right to refuse to sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 4545 E. Chandler Blvd. #300, Phoenix AZ 85048.

Signed by: _____

Signature of Patient or Legal Guardian

_____ Date

_____ Print Name of Legal Guardian

_____ Relationship to Patient