

Orange County Urology Associates, Inc. A Medical Group

25200 La Paz Road, Suite 200 • Laguna Hills, CA 92653
Phone (949) 855-1101 • Fax (949) 855-8710

Paul A. Brower, M.D., F.A.C.S. Richard A. Cerruti, M.D., F.A.C.S. Jennifer L. Gruenenfelder, M.D. Moses M. Kim, M.D. Ph.D. James P. Meaglia, M.D.

Terrence D. Schuhrke, M.D., F.A.C.S. Karan J. Singh, M.D. Aaron Spitz, M.D. J. Bradley Taylor, M.D., F.A.C.S. Neyssan Tebyani, M.D.

Authorization for the Use and/or Disclosure of Protected Health Information

PATIENT NAME: _____ DOB: _____

I authorize the use and/or disclosure of protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (*check all that apply*):

- Progress Notes
- HIV tests results specify: Yes No
- Hospital H+P's Discharge summaries operative reports date: _____
- Pathology Reports
- Imaging/Radiology Ultrasound CT nuclear medicine x-rays other: _____
- PSA(s) Recent BUN/Creatinine Infertility labwork other: _____
- Urinalysis/Urine Cultures since: _____
- Vaginal or urethral swabs
- EKG report(s) date: _____
- Cystoscopy report(s) date: _____
- All medical records
- Other (specify): _____

2. I authorize the following person(s) to **release** and/or disclose my protected health information:

3. I authorize the following person(s) to **receive** and/or discuss my protected health information:

4. I authorize my protected health information to be received by and or discussed with the following person(s) or family member(s):

Name _____ Relationship _____
Name _____ Relationship _____

5. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then the information may be re-disclosed by that individual and would no longer be protected.

6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (*e.g., a letter*) addressed to my doctor. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

7. This authorization expires _____ (*insert date or an event that triggers expiration*)

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Orange County Urology Associates, Inc. A Medical Group, nor will it affect my eligibility for benefits.

9. My protected health information will be used or disclosed upon request for the following purposes (*check all that apply*):

- Personal records
- Continued medical care
- Other (specify): _____

10. I understand that I have a right to inspect and receive a copy of my own protected health information to be used or disclosed in accordance with requirements of the federal privacy protection regulations. I certify that I have received a copy of the authorization.

Signature _____

Date _____

Name (*please print*) _____

Name of Personal Representative _____

Relationship of Representative _____