

Orange County Urology Associates, Inc. A Medical Group

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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: _____
 Other (specify): _____

For OCUA Office Use Only: ____ Records released to patient ____ Fee paid ____ Records faxed/mailed to other healthcare provider
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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 _____

PLEASE NOTE: There is a \$ 15.00 fee for records requested for personal use, no charge for records that are sent directly to other physicians.