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): _____

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 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.
5. 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.
6. This authorization expires _____ (*insert date or an event that triggers expiration*)
7. 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.
8. 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): _____
9. 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 _____