Northeast Georgia Urological Associates, P.C.
Authorization for Release of Protected Health Information (PHI)

First Name: _____ **Last Name:** _____

Date of Birth: _____ **S.S. #:** _____

Home #: _____ **Cell #:** _____

I hereby authorize the disclosure of my protected health information as follows:

- o All records for all dates of service
- o Records for the following date(s) of service: _____
- o Other: _____

The purpose of this release of information is for:

- o Transfer of records to another provider
- o Transfer of records to complete health records or information at another entity or service
- o Attorney
- o Personal use
- o Other: _____

PLEASE INITIAL ALL STATEMENTS

I understand the following:

____ I understand that my records are protected under HIPPA/PHI regulations.

____ I understand that under the Federal Protected Health Information regulations, I have the right to review my records and request amendments where appropriate.

____ I understand that my health information may be subject to re-disclosure and not protected by federal or state status (medical emergencies, reporting of communicable diseases as required under State Law, subpoenas duce tecum and government agencies upon appropriate and authorized court orders).

____ I understand that the specific information to be disclosed in my medical records may include information regarding drug use, counseling referrals and/or history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

____ I understand that I may revoke this authorization at any time by notifying the Administrator at Northeast Georgia Urological Associates in writing except that revocation will not cancel any action taken by Northeast Georgia Urological Associates upon the original Authorization for Release of PHI.

____ I understand this Authorization of Release will expire in 90 days from the date signed notice to receiving entities: Protected Health Information Disclosure Statement.

This information on the above patient has been disclosed to you from records protected by federal confidentiality rules 42 CFR pt. 2. Receiving entities are prohibited from further disclosure without the written consent of the above named patient. A general authorization for release is not sufficient for this purpose.

Please Circle One:

Releasing Records To Wanting Records From

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax #** _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____