NORTHEAST GEORGIA UROLOGIC ASSOC., P.C.

Authorization for Release of Protected Health Information (PHI)

To(releasing organization) _____
Address: _____

Last Name_____ First Name_____ Middle Initial____

Date of Birth: Month_____ Day_____ Year____ Social Security #_____

Phone Number_____ Email: _____

I hereby authorize disclosure of my protected health information as follows:
(Check all that apply)

- ○ Complete Medical Record for all services to include: History and Physical Exam; Progress Notes, Laboratory Tests, Physician Orders, X-rays Reports, Inpatient Admissions, Physical Therapy.
- ○ HIV test Results Travel Abroad/Visa and Entry Requirements Only
- ○ Athletic Injury Status: Specify Information_____
- ○ Records Related only to the following date(s) of service_____

The purpose of this release of information is for:

- ○ Transfer of Records to another provider
- ○ Transfer of Records to complete health records or information at another entity or service
- ○ Attorney
- ○ Personal Use
- ○ Other (Describe) _____

I understand the following (Please Initial all statements)
____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 record 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 record may include information regarding drug or alcohol use, counseling referrals and/or a 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, Northeast Georgia Urology in writing except that revocation will not cancel any action taken by Northeast Georgia Urology upon the original Authorization for Release of PHI
____I understand that this Authorization of Release will expire in 90 days from the date signed

Notice to Receiving Entities: Protected Health Information Disclosure Statement

The information on the above patient has been disclosed to you from records protected by federal confidentiality rules 42 CFR part2. 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.

Release of Information is to:

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number _____ Fax_____

Signature_____ Date_____

Witness Signature_____ Date_____