TEXAS UROLOGY SPECIALISTS
Urology Specialists, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_____Date of Birth_____Social Security #_____(optional)

I authorize the following individual or organization to disclose the above named individual's health information

Address _____ Phone _____

For the purpose of ☐ Continued Care ☐ Attorney/Legal ☐ Personal use ☐ Insurance ☐ Other

Please release the following:

___Problem List
___Progress Notes
___History/Physical Exam
___Medication List
___Immunization Record
___List of Allergies
___X-Ray/Imaging Reports from (date)_____to (date)_____
___X-Ray Films (date) _____
___Laboratory Results from (date) _____to (date) _____
___EKG Reports
___Genetic Testing Information
___Other Diagnostic Reports (Specify) _____
Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

X _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provide in CFG 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact office the manager/privacy officer.

X_____ X_____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient or Legal Representative

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Urology Specialists liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation:

X_____ X_____
Signature of Patient or Legal Representative Date
X_____ X_____
Relationship to Patient)if Legal Representative) Witness