

PF-3200 Standard Authorization of Use and Disclosure of Protected Health Information

Information To Be Released: I hereby authorize Mississippi Urology Clinic, PLLC to release/disclose the following confidential/protected health information.

Please **initial** each information type – if you are requesting the complete medical record you only need to initial the first line:

- Complete Medical Record, or more specifically,
- | | |
|--|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> X-ray/Ultrasound Reports |
| <input type="checkbox"/> Urodynamics Tests Results | <input type="checkbox"/> Inpatient Information |
| <input type="checkbox"/> Other (Specify): _____ | |

Purpose of Release: This purpose of the release/disclosure is:

- To transfer records to another provider
 For my personal use
 Hard copy requested Inspect in the office only
 To provide an Attorney with a copy of the record
 Other (Describe): _____

To Whom Released: The release/disclosure of information is specifically to:

Name of person/Organization: _____
Address: _____
City, State, Zip: _____

Expiration Date of Authorization: This authorization is effective for one year from the date of signing or through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to **Mississippi Urology Clinic**. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type): _____
Date of Birth: _____
Social Security Number: _____

Signature of Patient: _____
Date: _____

Signature of Patient Representative: _____
Relationship to Patient: _____
Date: _____