PF-3212 **Authorization of Disclosure of Protected Health Information By Another Covered Entity for Use by Mississippi Urology Clinic, PLLC**

Information to Be Released: I hereby authorize: _____
Address: _____
_____
to release/disclose the following confidential/protected health information to Mississippi Urology Clinic, PLLC (Please initial the appropriate lines):

_____ Complete Medical Record, or more specifically,

_____ History and Physical	_____ Clinic Notes
_____ Laboratory Tests	_____ Xray/Ultrasound Reports
_____ Urodynamics Tests Results	_____ Inpatient Information
_____ Other (Specify): _____	

Purpose of Release: This purpose of the release/disclosure is to transfer records to another provider/covered entity.

To Whom Released: The release/disclosure of information is specifically to (circle one):

Mississippi Urology Clinic, PLLC
1421 N. State Street, Suite 403
Jackson, Mississippi 39202
Attn: _____

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 Private 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: _____