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,

- ____ History and Physical ____ Clinic Notes
- ____ Laboratory Tests ____ X-ray/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
- ____ 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: ____________________