UROLOGY, P.C./UROLOGY SURGICAL CENTER
Authorization to Release Protected Health Information

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). By signing this authorization, I understand Urology, P.C./Urology Surgical Center is authorized to use and/or disclose my protected health information as specified herein. This authorization may expand, but not limit the use and/or disclosure to/from Urology, P.C./Urology Surgical Center for purposes of treatment, payment or health care operations.
By signing below, you acknowledge receipt of a signed copy of this authorization.

Signed by: _____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date

_____ _____
Printed Name of Patient Printed Name of Legal Guardian

_____ _____ _____
Patient's Address Social Security Number Date of Birth

*****Note: If signed by someone other than the patient we need written proof of your authority.**

I authorize the release of my Protected Health Information between the entities listed:

TO / FROM (circle):

Urology P.C./Urology Surgical Center
5500 Pine Lake Rd, Lincoln, NE 68516
(402)489-8888

TO / FROM (circle): Include full name with address, phone and fax numbers

_____

_____

_____

_____

Check the description of the information to be disclosed:

___ Complete medical record or,

___ Medical records from _____ to _____ or,
date date

___ Specific medical records as listed: _____.

State the purpose or need for which the information is to be used by the individual to whom information is to be released (i.e. personal, legal, benefits, state reporting, research, or other)._____.

In understand that when the information is used or disclosed because of this authorization, my protected health information may be subject to re-disclosure by the recipient. We will not have the ability to monitor whether your health information may be further used or disclosed by such parties and may no longer be protected health information. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws. In addition, I understand that disclosures pursuant to this authorization are not subject to HIPAA accounting rules.

We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, you failure to sign this authorization will prevent us from providing such treatment.

This authorization will expire on _____. If no date is written, the
Expiration Date
Authorization shall expire twelve months from the date of signature on this form

I specifically authorize the release of data and information relating to, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable line):_____HIV (AIDS virus), _____sexually transmitted diseases, _____mental health, or _____drug and/or alcohol abuse.

I understand that I or my legal representative retains the right to revoke this authorization. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation. To revoke this authorization, I/We must submit in writing the following:

- Patient's name
- Effective date of the authorization
- Recipients of protected health information
- Patient's desire to revoke this authorization
- Date of the revocation, and the patient or legal guardian's signature

All revocations must be sent to the Privacy Officer at Urology P.C., 5500 Pine Lake Road, Lincoln, NE 68516.

I fully understand and accept the terms of this authorization.

FOR OFFICE USE ONLY

Authorization verified by _____ on _____.

Authorization added to the patient's medical record on _____.