THE UROLOGY TEAM P.A.

Authorization for Release of Protected Health Information

By signing this form, I authorize The Urology Team P.A. to release confidential health information about me, by releasing a copy of my medical records, or protected health information described below to the person(s) or entity listed below.

Patient Full Name:_____ Date of Birth: _____ SS#: _____

Telephone #:_____ Alternate Number:_____

This information may be disclosed to and used by the following individual or organization:

Physician or Facility:_____ Phone #:_____ Fax #:_____

Address: _____ City: _____ State: _____ Zip: _____

There is no charge to the patient if the records are faxed or mailed directly to a MD office or Medical Facility from The Urology Team P.A.

Please release the following information regarding Treatment From: _____ to _____.

Reason or purposes for this release of information is as follows: _____

☐History/Physical ☐Progress Notes ☐Medication List ☐ Imaging Reports/X-Rays ☐ Lab/Pathology Results

□ Other_____

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV, It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. ___Yes, I consent to the release of this information. **___ No,** I do not consent to the release of this information.

- **I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.**
- **I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the department or organization releasing information.**
- **I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.**
- **Unless otherwise stated this authorization will expire in 6 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 provided in CFR 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 questions about disclosure of my health information, I can contact the Privacy Officer. <u>If I am the patient and requesting the patient records directly, I understand that my medical records 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 UTPA liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.</u>

_____ / _____

Signature of Patient or Personal Representative **Date**

_____ / _____

Print name of Patient or Personal Representative **Description of Personal Representative's Authority**

Date Requested: _____ # Pages copied: _____ Charge to patient or facility:_____

Date Received: _____ Cash/Credit Card:_____ Check #:_____ Initials: _____