UROLOGICAL SURGICAL ASSOCIATES
RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize UROLOGICAL SURGICAL ASSOCIATES to disclose my health information as described below:

PURPOSE of RELEASE: _____

DATE: _____

_____ _____ _____
PATIENT NAME Date of birth Social Security #

_____ _____
ADDRESS (street, city, state, zip code) Telephone

Treatment dates requested: FROM _____ to _____

The following information may be disclosed: (please check the items you want released)

_____ physician notes
_____ lab results
_____ diagnostic studies (x-rays, ultrasound, UDE, MRI or CAT Scans)
_____ operative records/pathology reports
_____ complete record

RELEASE TO:

NAME: _____ PHONE: _____
(include area code)

ADDRESS: _____
(street, city, state, zip code)

_____ Paid _____ Check # _____ Cash _____ Mail _____ Pick UP

The Right to Inspect & Get Copies of PHI - 45 C.F.R. 164.524.: CE must give patients access to their PHI, i.e. the right to inspect and get copies (not originals) of PHI. Under State law, physicians may charge a fee of up to $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the physician may charge up to $10.00 to cover miscellaneous costs associated with retrieval of the record.)

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that information then may not be protected by federal confidentiality rules.

Right to revoke: Unless otherwise revoked by me, this authorization is valid for 3 months from the date above. Revocation of this document must be made in writing to the Office Manager at Urological Surgical Associates. I understand that the revocation will not apply to information already released.

SIGNATURE:

_____ _____
Print or type patient name Signature of patient

_____ _____
Signature of patient representative Relationship

_____ _____
Witness Date