MISSISSIPPI
UROLOGY CLINIC, PLLC

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 _____ 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
____ 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: _____ Date: _____

Relationship to Patient: _____