AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION BY ANOTHER COVERED ENTITY FOR USE BY MISSISSIPPI UROLOGY CLINIC, PLLC

INFORMATION TO BE RELEASED: I hereby authorize: **MS Urology Clinic** **Fax: 601-353-3654**
Address: **501 Marshall Street Suite 301, Jackson, MS 39202**

to release/disclose the following confidential/protected health information to Mississippi Urology Clinic, PLLC (Please initial the appropriate lines):

_____ 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/covered entity. **Authorize to act on my behalf**

TO WHOM RELEASED: The release/disclosure of information is specifically to:

NAME: ____

RELATIONSHIP TO PATIENT: ____

ADDRESS: ____

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 Private 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: _____________________________________