Advanced Urology Institute, LLC

Date: _____ **AUTHORIZATION FOR RELEASE OF INFORMATION**

Name: _____ Date of Birth: _____

Advanced Urology Institute, LLC is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please mark each area of information that may be given to the person/entity listed on the left in the same section.
○ Answering Machine	○ Messages regarding appointments, lab tests/ x-rays or procedures ○ Any other information regarding treatment ○ Any information regarding Medications
○ Spouse (Provide Name and DOB) _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)
○ Parents/Children (Provide Name and DOB) _____ _____ _____ _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)
○ Other (Provide Name and DOB) _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. _____

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Institute, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

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ACKNOWLEDGEMENT OF PRIVACY NOTICE

In compliance with HIPPA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Institute, LLC. I understand a copy of this policy is available for me to take home for my records.

_____ _____

Signature of Patient or Personal Representative Date