John Pirani, M.D.
Manish Shah, M.D.
Merle Wade, M.D.
Dawon Stephens, D.O.
Lauren N. Hendrix, M.D.

Clinical Urology Associates, P.C.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or distribution of my individually identifiable protected health information (PHI) as described below. The authorization includes any information related to drug and/or alcohol abuse/treatment, communications with psychologists or psychiatrists, or pertaining to sexually transmitted diseases, if they are part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and no longer be protected by federal privacy regulations.

Patient Name:___________________________ Medical Record Number:________
Patient SSN:____________________________ Patient DOB:______/_____/______
Persons Receiving Information:____
Fax Number:____

Specific Information to include: ______ **All Information**

____ Face Sheet _____ Discharge Information ___ History and Physical
____ Pathology Report _____ Medication List ___ Lab Reports
____ Clinic Notes _____ X Ray Reports ___ Op Notes

____Other: Please describe: ____
____

The purpose of the disclosure is: ___ My personal Records ____ Sharing with other providers ____ Other: ____

The patient or patient's representative must read and initial the following attached statements:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

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Initial_____________________

I understand that I may revoke this authorization at any time by notifying the Clinical Urology Privacy Office in writing, but, if I do, it will not have any effect to the extent Clinical Urology Associates, P.C. took action in reliance on this authorization.

Initial______________________

I understand that Clinical Urology Associates, P.C. may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this authorization, except under the following circumstances:

- **Participating in research projects may be conditioned on my signing of an authorization to use and disclose PHI in the research.**
- **Initial enrollment in health plans can be conditioned on signing an authorization for the health plan to review PHI to make eligibility determinations.**
- **Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.**

This authorization will expire ____________________________________
(If this is blank it will expire six months from the date of signing)

Signature of Patient or Patient's Representative ________________________________

Printed Name of Patient: ____

Printed Name of Patient's Representative: ______________________________________

Relationship to Patient: ____

Date: ____