PENINSULA UROLOGY ASSOCIATES, P.A.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFOMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT NAME:	DATE OF BIRTH	SSN
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE #

The following individual or organization is authorized to make the disclosure:

- ☐ PENINSULA UROLOGY ASSOCIATES, P.A
- ☐ OTHER (*please specify)* _____

This information may be disclosed to and used by the following individual or organization:

- ☐ PENINSULA UROLOGY ASSOCIATES, P.A
- ☐ OTHER (*please specify)* _____

TREATMENT DATES:	PURPOSE OF REQUEST

The following information is to be disclosed: *(please check boxes that apply)*

YES	NO	
		Physician notes
		Lab results
		X-Ray reports
		MRI scans
		Cardiac studies
		Complete record
		Other

FEES: I understand there may be a charge for copying and handling of my request. I understand all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

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 re-disclosure and that the information then may not be protected by federal confidentiality rules

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization

OTHER REQUESTS:

A. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
B. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked this authorization will expire on the following date, event, or condition:
(*if I do not specify an expiration date, event, or condition this authorization will expire in 6 months)*

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE.	DATE

If signed by legal representative, please list relationship to patient.