ADULT PEDIATRIC UROLOGY & UROGYNECOLOGY

AUTHORIZATION FOR THE USE OR DISCLOSUREOF HEALTH INFORMATION

Patient Identification

Name: _____Date of Birth:_____
Address: _____ Phone: _____
City/State/Zip: _____
Maiden/Previous Names/Nickname: _____
Social Security Number: _____

Provider (Who is releasing information?)

Provider/Facility Name: _____
Address: _____ Phone: _____
City/State/Zip: _____ Fax:_____

Disclose Information To: (Where is information to be sent?)

Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Information to be Disclosed

☐Clinic Progress Notes ☐Pathology Reports ☐All Records
☐Lab Data ☐Radiology Reports ☐Other
_____
_____
_____

Purpose of Disclosure

☐Continuing Medical Care ☐Consult/2nd Opinion ☐Out of town move
☐Insurance Claim ☐Legal ☐Personal
☐Other (Specify) _____

Expiration Date

This authorization shall expire upon the earlier of _____ or 180 days from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation

You have the right to revoke this authorization at any time by providing us with written notice by certified mail, fax or hand delivery to the following address:

Adult & Pediatric Urology& Urogynecology, P.C.
10707 Pacific Street, Suite 101
Attn: Privacy Officer; Katie Krimmel
Omaha, Nebraska 68114

- Phone (402) 399-7840
- Fax (402) 397-8703

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of patient/representative Signature Date

_____ _____
(Relationship to patient, if signed by representative) (Witness-optional)

Please supply proof of authority to act. For minors, proof only required if other than parent.