AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Identification	Name: ______________________ Date of Birth: ______________ Address: ______________________ Phone: ______________ City/State/Zip: ______________________ Maiden/Previous Names/Nickname: ______________________ Email: ______________________
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: ______________ **Check One:** Fax to Doctor/Self: _____ Email to Patient Only: _____ Patient Pick Up Only: _____
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: Medical Records 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.

01/06/2021