# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize ______________________________ to disclose the following information from the health record of:

**Patient Identification**

| Patient Name | Date of Birth | Medical Record # |
|---|---|---|

| Address | City | Phone Number |
|---|---|---|

Dates of Service: From ______________________ To ____________________

**Information Requested**
___Relevant Medical Record ___Lab Reports ___X-ray Reports
___Pathology Report ___Operative Report ___Billing Record
___Specify: ________________________________________

**Purpose**
___Self ___Transfer Care ___Second Opinion ___Attorney Request
___Other: ________________________________________

**Information To Be Sent To:** ________________________________________
Company/Person/Facility

| Address | Suite | City/State | Zip |
|---|---|---|---|

| Phone Number | Fax Number |
|---|---|

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Central Arizona Urologists will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization this authorization at any time, except to the extent that action based on this authorization has already been taken. Central Arizona Urologists' Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, it will expire 6 months from the date signed or as specified ________________.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that received the information.

I release CAU, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

______________________________ ________________
Signature of Patient Date

______________________________ ________________
Signature of Legal Representative Relationship to Patient

If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign. (Separate release form)