SOUTHLAND UROLOGY

HIPAA Authorization / Release of Medical Information Form

Patient Name:_____ Date of Birth:_____

BY SIGNING BELOW, I AUTHORIZE *Southland Urology* TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

Relationship: Name of Designated Person(s):

Spouse: YES NO _____

Children: YES NO _____

Caregivers: YES NO _____

Parents: YES NO _____

Persons listed above may also have permission to pick up prescriptions, x-rays, etc. and I understand that *Southland Urology* will ask for identification of the person picking up medical information.

Southland Urology may leave a detailed message, such as appointment reminders and test results on my voicemail:

Home: YES NO Phone #_____

Cell: YES NO Phone #_____

Work: YES NO Phone #_____

I understand that I have the right to revoke this authorization in writing at any time by giving written notice to the practice's Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the Personal Health Information (PHI) or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

This authorization shall be in force and effect until superseded by a later-dated authorization or written revocation submitted to the practice's Privacy Officer.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

(Copy Available Upon Request)

Revised 11/06/2017