AUTHORIZATION FOR RELEASE OF INFORMATION TO/FROM UROLOGY PARTNERS OF NORTH TEXAS, PLLC

I hereby authorize:

_____
Healthcare Provider that records are being **requested from**

_____
Address, City, State, Zip

_____ _____
Telephone # Fax #

To release the following information to:

_____
Healthcare Provider that records are being **sent to**

_____
Address, City, State, Zip

_____ _____
Telephone # Fax #

to disclose my individually identifiable patient health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____
Patient Name Date of Birth Social Security Number

_____ _____
Patient Address Patient Phone Number

Information to be Released (Check all that apply): _____
Specific Date(s) of Service (or) Indicate ALL DATES

Complete Medical Records	_____	**Laboratory Reports**	_____	**Registration & Billing Records**	_____
Office/Consultation Notes	_____	**Radiology Reports & Films**	_____	**Other (please specify)**	_____
Operative Reports	_____	**Pathology Reports**	_____	**Billing Records (specify dates)**	_____

This authorization is given without restrictions with the understanding that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law and I acknowledge that a photocopy of this authorization is as valid as the original. I understand that this authorization will expire 180 days from the date of this authorization unless I specify otherwise.

Urology Partners of North Texas, PLLC, its employees, officers, physicians and associate providers may not be held responsible for the re-disclosure of protected health information or medical records by an outside entity and are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and herein. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.

I understand that I have the right to inspect the disclosed information and I further understand that I may revoke this authorization at any time by notifying this practice in writing. I understand that the written notification must be signed and dated with a date that is later than the date on this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The revocation will not affect any actions taken before the receipt of the revocation.

_____ _____
Patient or Legal Representative Name **Patient Date of Birth**

_____ _____
Patient or Legal Representative Signature **Date of Signature**

_____ _____
Legal Representative Relationship to Patient (if applicable) **Expiration Date of Authorization**
Unless otherwise noted, expires 180 days from date of signature above

_____ _____

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Witness Signature **Date of Witness Signature**