Urology of Indiana

Authorization to Use and Release Protected Health Information (Release to Urology of Indiana)

I, _____ who resides at _____ in the city of _____ in the state of _____ hereby authorize

Name: _____

Address: _____

City, State, Zip: _____

to disclose the following specific medical information to Urology of Indiana, LLC by:

☐ Mail : 679 East County Line Road Greenwood, Indiana 46143

☐ Fax : 317-807-0140

My authorization extends only to those data elements/documents indicated below:

☐ Statements of charges or payments

☐ Records of visits (all visits)

☐ Record of visit for a specific date or dates. Specific dates included are limited to: _____

☐ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

☐ All of the above

☐ Other, Specify: _____

☐ Mental Health and/or alcohol and drug abuse treatment

☐ HIV Information

☐ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. That a photocopy or fax of this authorization is as valid as this original.
3. That a potential exists for information I authorize to be re-disclosed by the recipient.
4. That I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty-day (60) period from the date it is signed, or sooner if noted below.

_____ Patient Signature, or Patient's Legal Representative, or patient's parent or Guardian if under 18

_____ Social Security Number

_____ Patient's Name, Printed

_____ Date