Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Johnson City Urological Clinic, P.C. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity/Person to Release Information Description of information to be released

{ } Home Answering Machine
{ } Voice Mail
{ } Financial { } Appointment { } Results of Lab test
{ } Results of X-ray test { } Prescription Information
{ } Other_____

{ } Spouse
Name: _____
{ } Financial { } Appointment { } Results of Lab test
{ } Results of X-ray test { } Prescription Information
{ } Other _____

{ } Other:
Name: _____
Name: _____
Name: _____
{ } Financial { } Appointment { } Results of Lab test
{ } Results of X-ray test { } Prescription Information
{ } Other _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative **Date**

***If a Personal Representative signs this form we must have necessary documentation.**