The Urology Center, P.C.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I hereby authorize the office and it's employees listed below:

Name/Hospital/Doctor Office/Business or other	
Address	Phone Number
City/State/ZIP	Fax Number
For the purpose of:	

to disclose from the records of:

Patient Name	Patient Number
Address	Date of Birth
City/State/Zip	Phone

the following information:

- ☐ Laboratory report
  - ☐ PSA
  - ☐ BUN/Creatinine
- ☐ Pathology report
- ☐ Radiology Report
  - ☐ US report
  - ☐ CT scan
  - ☐ IVP
  - ☐ KUB
- ☐ Emergency Room Report
- ☐ Operative Report
- ☐ Clinical Office Notes
- ☐ Entire Medical Records
- ☐ Other_____

I understand that this will include information relating to (*check if applicable*):

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ☐ Mental Health Information
- ☐ Mental Health Joint Counseling Sessions (Please note that an Authorization Form must be obtained from all individuals present during such sessions.)
- ☐ Psychotherapy notes (A separate Authorization Form must be signed for disclosure of psychotherapy notes)
- ☐ Treatment for alcohol and/or drug abuse

I understand that this will cover information related to all dates of service unless I specify otherwise below:

Covering the periods(s) of care: from _____ to _____

This information will be disclosed to: The Urology Center, P.C.
111 South 90th Street
Omaha, Nebraska 68114
Phone: (402)397-9800
Fax: (402)397-7591

If no purpose is stated, then the purpose of the disclosure will be "at my request".

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will **not** have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration. This authorization shall expire upon the earlier of _____ or one year from the date of this authorization. After the expiration date, we will need to obtain a new authorization.

Revocation. You have the right to revoke this authorization at any time by providing us with written notice by certified mail, fax or hand delivery to the following address: The Urology Center, P.C. Fax: (402)397-7591
Attn: Privacy Officer
111 South 90th Street
Omaha, Nebraska 68114

When we receive your revocation, we will immediately stop using or disclosing their health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Signature of Patient		Date
Signature of Parent/Legal Guardian if Patient is a Minor/Power of Attorney/Guardian	Relationship to Patient	Date