ATLANTIC UROLOGY CLINICS

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

All sections of this authorization form MUST be completed to be considered valid

Patient Name: _____Date of Birth: _____/_____/_____
Address: _____City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from GenesisCare USA be disclosed to:
Recipient Name: _____
Address: _____City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I request the following PHI to be released from my medical record(s):
Name of Physician: _____
Specific Treatment Dates: _____ to _____
☐ Consultation Reports ☐ Diagnostic Films ☐ Dosimetry Records ☐ Laboratory Results
☐ Physician Notes ☐ Portal Films/Simulation Films ☐ Progress Notes ☐ Radiology or Imaging Reports
☐ Surgery/Pathology ☐ Complete Medical Record ☐ Billing Records ☐ Genetic Records
☐ Other (please specify): _____

Purpose for requesting information:
☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Disclosure Format: ☐ US Mail – paper format ☐ Fax (*healthcare provider only*) ☐ Secure E-mail
☐ CD/Flash drive – secure format or ☐ Other *(please specify):* _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- The information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the _____at the following address:_____. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire *one year* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative
Signature*_____Date_____Time_____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____
*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*)
Driver's License State: _____Number: _____
Witness Signature _____**Date**_____**Time**_____

INSTRUCTIONS FOR COMPLETING THE PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Complete the first section with patient name, date of birth, address, e-mail address and day time telephone number.

2. **I request my records to be sent to:** Complete the name of the individual/company where you would like us to send the copies to. If the copies are for you, state "Self" in the name field. Also, complete the contact information including phone, address and fax number if the copies are to be sent to another health care provider. If the records are going to be picked up, the name of the individual picking up the records should be listed.

3. **I request the following Protected Health Information (PHI) to be released from my medical record(s):** Mark the documents that you are requesting. Test results when marked individually are generally for specific dates of service as indicated in the next section.

4. **Specific treatment dates:** If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.

5. **Purpose for requesting information**: Please mark if the records are for continuing care, personal, insurance, legal, or other.

6. **How information is to be received (if not marked, mail is the default):** Paper records or CDs will be mailed to the address provided. Records can be sent via secure e-mail if requested. Records will be faxed only to another health care provider. Records can be picked up between the hours of _____ Monday through Friday at _____. Please call _____ at _____ in advance of picking up records. When picking up records in person, a photo ID will be required as well as a copy of any legal papers (power of attorney, executor of estate, proof of custody, etc.).

7. **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate etc.) sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by an authorized representative.

8. **Driver's License or Photo ID:** This will be required when picking up records at either of our locations as listed above.

9. **Witness Signature:** A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please call _____ at _____ if you have any further questions.