PREMIER UROLOGY

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE: _____

I hereby authorize _____to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____FAX: _____
ADDRESS: _____

_____

The following information is to be disclosed: (please check off those that apply)

Department: Urology/Gynecology
Physician notes _____ Dates _____
Lab results _____ Dates _____
X-Ray reports _____ Dates _____
Operative reports _____Dates _____
COMPLETE RECORD _____
Other: _____

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative Date

_____ _____

Please note that all record requests are fulfilled by CIOX via mail. All areas of this form must be completed in its entirety in order to be completed. All record requests will be processed/fulfilled in 5-7 business days.

The completed form must be faxed to 845-452-4314. If you do not have the capabilities to fax, please mail this completed request form to 50 Eastdale Ave N. Poughkeepsie, NY 12603 or bring it to one of the below Premier Urology locations.

50 Eastdale Ave N. Poughkeepsie, NY 12603 *111 Mary's Ave. Kingston, NY 12401*

955 Little Britain Rd. New Windsor, NY 12553