AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

I authorize Lancaster Urology to:

☐ Receive from: OR ☐ Disclose to:

Facility Name:

Faciltiy Address:

Facility Phone: Facility Fax:

Date information needed by:

Please check all that apply:

☐ Complete Medical Record ☐ Lab/X-ray/Imaging reports ☐ Pathology reports
☐ Op/Hosp ☐ Other: (Please specify):

The purpose for disclosing the above information:
(Please check all that apply:)

☐ Continuation of care ☐ Second Opinion ☐ Change of Insurance ☐ Legal
☐ Relocating ☐ Other: (please specify):

Re-disclosure: I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may be re-disclosed and may no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse/trtm or referrals for treatment; HIV information; and mental health services may NOT be re-disclosed per Pennsylvania state law and regulation and/or federal confidentiality rules.

If any of the below information is ***applicable*** and you ***DO NOT*** wish to have released, please check all that apply:

☐ HIV/AIDS related records ☐ Mental health records ☐ Drug/Alcohol abuse/trmt
☐ Sexual abuse/assault

THIS AUTHORIZATION SHALL EXPIRE ***90 DAYS*** FROM SIGNATURE DATE, UNLESS SOONER REVOKED BY ME. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT PREVIOUSLY AUTHORIZED DISCLOSURE HAS BEEN ACTED UPON.

_____

Signature of Patient/Guardian: _____ Date: _____

Other person authorized to sign authorization:
Relationship to patient:

NOTE: if Power of Attorney - please attach a copy of POA papers to this authorization

Mail or fax to: Lancaster Urology
2106 Harrisburg Pike; Suite 200; PO BOX 3200
Lancaster, PA 17604
Attn Medical Records
Fax #: 717-393-2782