CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

Augusta Urology Associates, LLC
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Augusta, GA 30901
(706)722-0705 f(706)722-7315

Patient name: _____ Date of birth: _____

This form applies only to the release and disclosure of information. It is not for treatment or intended for any other purpose.

By signing this form, I authorize the use, release, or to disclose the protected health information described below to:

Name and address/fax of person/organization to whom information may be sent:

_____

Transmit this information on or about (information will not be resent absent reauthorization): ____/____/____.

I authorize the following information to be sent to the above person/organization (check all that may apply):

- ☐ Copies of all medical records
- ☐ Copies of medical records for the date(s): _____
- ☐ Copies of medical records relating to the following treatment or condition: _____
- ☐ Other (specify):_____
- ☐ History and Physical Examination
- ☐ Lab Reports
- ☐ Billing Records

This protected health information is disclosed for the following purposes: _____

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted disease (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

I understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand the information released in response to this authorization may be re-disclosed to other parties. Privacy laws may no longer protect it.

I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____

Signature (patient or legally authorized individual) Date