

### Authorization for Use and Disclosure of Protected Health Information

I hereby authorize \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release information from my records to:

**Augusta Urology Associates**  
**4350 Towne Centre Drive, Suite 2200**  
**Evans, GA 30809**  
**PH (706) 722-0705 FAX (706) 722-7315**

The purpose or need for this release of information is: \_\_\_\_\_

The Specific information to be disclosed is:

- |  |   |
|--|---|
| <input type="checkbox"/> Physician's chart notes | <input type="checkbox"/> Operative Reports          |
| <input type="checkbox"/> X-Ray reports           | <input type="checkbox"/> Urological related records |
| <input type="checkbox"/> Ultrasound report       | <input type="checkbox"/> Financial records          |
| <input type="checkbox"/> Pathology Reports       | <input type="checkbox"/> CT Scan                    |
| <input type="checkbox"/> Other _____             |   |

Information which may not be disclosed: \_\_\_\_\_

Note: Special dates of interest: \_\_\_\_\_ to \_\_\_\_\_

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

**Authorization must be signed by the patient, or patient's legal representative.**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand this authorization will expire one year from the date signed unless otherwise specified:

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Signature or Personal Representative

\_\_\_\_\_  
Date

As a personal representative, I have authority to act for the individual because I am: \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date