PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES
(RELATIVE OR OTHER PERSON)

By signing this authorization, I authorize Consultants in Urology to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.
This authorization permits Consultants in Urology to use or disclose to:
(Please note relative, friend or other person to whom we may disclose information)

_____

_____

I authorize the following information to be released (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc):

_____

_____

This authorization will expire on April 14, 2013.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Consultants in Urology has acted in reliance upon this authorization. My written revocation must be submitted to Consultants in Urology's Privacy Officer at 275 Orchard Street, Westfield, NJ 07090.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Patient's Date of Birth Patient's Social Security Number