Authorization to Release Health Information

Patient Name_____ Date of Birth_____
Address_____
City_____ State_____ Zip_____
Telephone_____ Email: _____

I hereby authorize Urologic Surgeons, Inc. and Dr. Bruce Garber, to disclose my protected health information (PHI) as described below. I understand the PHI may include information relating to sexually transmitted diseases, HIV/AIDS, psychiatric care/treatment, and alcohol and drug abuse. I specifically authorize the release or disclosure of this information.

This PHI is to be disclosed for the following purpose:
_____

I authorize the following PHI to be released from my medical records:
____Operative note
____MRI compatibility information
____Recent notes
____All pages
Federal and state laws permit a per-page fee to be charged for the duplication and mailing of medical records. We will notify you of the exact charge prior to forwarding your PHI.

I request my PHI be released **to myself (circle), or to:**
Name, address, fax number: _____
_____
_____

I understand that this authorization is voluntary, and will automatically expire 180 days after the date of signature on this form. I understand that I may revoke this authorization at any time by notifying Urologic Surgeons, Inc. in writing of my desire to revoke. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may then no longer be protected by relevant federal and/or state privacy laws. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that if the entity receiving my PHI is not a health plan or healthcare provider, the PHI will not be protected by federal and state privacy laws. My refusal to sign this authorization will not affect my ability to receive treatment.

_____ _____
Signature of Patient Date

_____
Print Name

Send completed & signed form to: **Urologic Surgeons, Inc., Box 686, Bryn Mawr, PA 19010**
Or scan and email (unencrypted email is not secure) to: **urologicsurgeons@comcast.net**