UROLOGY OF CENTRAL PENNSYLVANIA, INC
Authorization for the Release of Protected Health Information

Name of the person executing this authorization: _____

I hereby authorize _____to release health information about me to:

Name of recipient: _____
Contact person (if recipient is an entity): _____
Address: _____
Telephone: _____ E-mail: _____

The information to be released shall be limited to the following:

☐ Medical Record (complete)	☐ History and Physical	☐ X-Ray/Imaging Reports
☐ Face Sheet	☐ Consultation Reports	☐ Laboratory Test Results
☐ Discharge Summary	☐ Operative Reports	☐ Cardiovascular Reports

☐ Other (please specify): _____

The purpose of the disclosure is as follows:

_____
_____
_____
_____

The information will be released in the following manner:

☐ In person ☐ Mail or other delivery service ☐ Fax ☐ E-mail

☐ Other (please specify): _____

I understand that this disclosure will include (check if applicable):

☐ Information relating to AIDS or HIV infection
☐ Treatment for substance and/or alcohol abuse or dependency
☐ Psychotherapy notes or other information relating to mental health or psychiatric care

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV related Information Act. My signature below authorizes the release of information protected by these Pennsylvania statutes.

I understand that I have no obligation whatsoever to disclose information from my record, and that the above mentioned medical facility cannot withhold treatment from me based upon my failure to execute this authorization, unless the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. The above mentioned medical facility, its employees, officers, and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from the above mentioned medical facility upon request.

THIS AUTHORIZATION SHALL EXPIRE ON ____/____/_____, BUT IN NO EVENT SHALL THIS AUTHORIZATION EXPIRE MORE THAN ONE YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED.

Patient or Patient Representative

Date

If signed by Patient Representative, please describe power/authority to act on patient's behalf:

This document shall be kept on record for at least six years from the date above.