ACADEMIC UROLOGY

Pottstown | Phoenixville

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I, ________________________________, hereby authorize ________________________________ to disclose the following protected health information to:

Academic Urology

20 Sunnybrook Road	824 Main Street, Suite 301
Pottstown, PA 19464	Phoenixville, PA 19460

The protected health information is being used or disclosed for the following purposes:

____

The information to be disclosed is:

____

This authorization shall be in force and effect for 90 days, unless revoked earlier.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer where I am requesting records from. I understand that a revocation is not effective to the extent that we have relied on the authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal and state law.
________If initialed, this authorization includes the release of HIV and AIDS related information and test results if included in my medical record. I authorize release of this information to the above named for the purpose of continuing care.

______________________________	______________________________
Name of patient or representative & DOB	Signature of patient or representative
______________	______________________________
Date	Description of patient representative
______________	______________________________
Date	Witness signature

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