



ACADEMIC UROLOGY

Pottstown | Phoenixville

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I, _____, here by authorize Academic Urology to disclose the following protected health information to:

This 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 **Privacy Officer, Academic Urology, 20 Sunnybrook Road Pottstown, PA 19464.** 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.

Academic Urology, will not condition treatment or whether or not I provide authorization for the requested use or disclosure.

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 the medical record in possession of Academic Urology. 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