

Urology Associates of North Texas
HIPAA Medical Records Release Authorization Form

I, _____, date of birth, _____, hereby authorize **Urology Associates of North Texas, L.L.P. (UANT)** to disclose the following information by: ___Mail ___Pick Up to the following individual or entity:

Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____

There will be a minimum fee of \$25.00 for all records requested.
All Records will be provided on a CD for your convenience.

For the Purpose of: ___ Consultation/Coordination of Care ___ Transfer of Care
Other: (please specify) _____ Appointment Date: _____

I hereby authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

I hereby authorize the release of my complete health record with exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

OR

I hereby authorize the release of following information:

- Records for dates of service from _____ to _____
- Progress/Consult reports only
- Lab results only
- Pathology results only
- Radiology results only
- Diagnostic results only (all lab/pathology/radiology)
- Hospital records
- Other (please specify) _____

This authorization is given freely with the understanding that:

1. A photocopy or fax of this authorization is as valid as the original.
2. I may inspect or copy the protected health information to be used or disclosed. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
3. I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization Notice to Urology Associates of North Texas at P.O. Box 120549, Arlington, TX 76012, Attn: Medical Records Manager.
4. UANT and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. This authorization is valid from the date signed below until the expiration date noted below.
5. I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that authorization is required for research-related treatment, in which case you may refuse that research-related treatment).

Patient's Printed Name: _____ **Date of Birth:** _____

Patient/Legal Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____ **Expiration Date of Authorization:** _____

Witness: _____ **Date:** _____

Office Use Only

Reviewed by: _____ Fee Collected: _____ Date: _____

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