HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This authorization affects your rights regarding the privacy of your personal healthcare information.
Please read it carefully before signing.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be affected by my signing or not signing this release.

PLEASE SELECT OPTION A (or) B:

☐ **A**. I hereby authorize Urology Associates of North Texas, L.L.P. ("UANT") to use and/or disclose the protected health information described below for the purpose(s) of treatment and care. **(Select one of the options below)**

____ 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).

____ 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):_____

Complete this Section if you checked either of the options above:
I authorize UANT or its Business Associates to release information to the following family members or friends for the period of health care from (**PLEASE CHECK ONE**)
□ All past, present and future periods **OR** □ _____ to _____

Name _____ Relationship_____
Name _____ Relationship_____
Name_____ Relationship_____

☐ **B**. Do not discuss/release my medical records or private information to anyone (including family members) or any entity. This option is not available for our minor patients; we must have written documentation indicating the adult caregiver(s) with whom we may discuss the child's care.

This authorization shall be in force and effect until _____ (date or event) or until properly revoked by me at which time this authorization expires. 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.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law. 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.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA, federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

You have the right to receive a copy of this HIPAA privacy authorization