WASHINGTON HEIGHTS UROLOGY, PC

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I am a patient of Washington Heights Urology, PC. (the "Practice") and hereby authorize the use or disclosure of my protected health information ("Information") by the Practice, or another business engaged by the Practice to act on its behalf, as described below. I understand that this authorization is voluntary.

Name of Patient: _____ **DOB**:_____

Address of Patient:_____

Phone of Patient:_____ **Disclosed to**: _____

Specific description of Information to be disclosed (including date(s)): _____

_____

_____

_____

The patient or the patient's legal representative must read and initial the following statements:

a. I understand that the patient's health care and the payment for his/her health care will not be affected if this form is not signed. Initials:_____

b. I understand that this Authorization will expire on __/__/____ (DD/MM/YR) Initials:_____

c. I understand that I may revoke this Authorization at any time by notifying the Practice in writing, but if I do, it won't have any effect on any actions taken before the Practice received the revocation. Initials:_____

d. I understand that there is a potential that the recipient of the Information may redisclose the Information and the Information will no longer be protected. Initials:_____

e. I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics. **IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.**

_____

_____

Signature of patient or patient's legal representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's legal representative:_____

Description of authority to act for the patient:_____