PF-3200 **Standard Authorization of Use and Disclosure of Protected Health Information**

Information to Be Released: I hereby authorize Columbus Urology, PLLC to release/disclose the following confidential/protected health information to:

_____

I hereby authorize_____ to release/disclose the following confidential/protected health information to Columbus Urology, PLLC.

Please Initial each Information type – If you are requesting the complete medical record you only need to initial the first line:

____ Complete Medical Record, or more specifically,

____ History and Physical ____Clinic Notes
____ Laboratory Tests ____X-ray/Ultrasound Reports
____ Urodynamics Tests Results ____Inpatient Information
____ Other (Specify):_____

Purpose of Release: This purpose of the release/disclosure is:

____ To transfer records to another provider
____ For my personal use
____ Hard copy requested ____Inspect in the office only
____ To proved an Attorney with a copy of the record
____Other (Describe):_____

To Whom Released: The release/disclosure of Information is specifically to:

Name of person/Organization: **Columbus Urology**
Address: **321 Hospital Drive**
City, State, Zip: **Columbus, MS 39705**
Phone: **662-327-2921** **Fax: 662-328-6858**

If more than 20 pages please mail.

Expiration Date of Authorization: This Authorization is effective for one year from the date signing or through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Columbus Urology, PLLC. You should contact the Private Officer to terminate this authorization.

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print): _____
Date of Birth: _____
Social Security Number:_____

Signature of Patient: _____
Date: _____

Signature of Patient Representative: _____
Relationship to Patient: _____