Urology Specialists, PC
4704 Whitesburg Drive, Suite 100
Huntsville AL 35801
Tax ID: 63-1185663

Authorization Form for Release of Information

Charges will only incur if records are printed and picked up

- Processing Fee: $5.00
- Pages 1-25: $1.00
- Pages 26-50: $0.50
- Pages 51+: $0.25

Patient Name (print): ___________________________ Date of Birth: ______________

Maiden name or any previous name (s): ______________________________________

Social Security Number: _____-____-_____ Telephone: _______________________

I HEREBY REQUEST AND AUTHORIZE:
Name of person(s) or organization(s): Urology Specialists, P.C.

Address: 4704 Whitesburg Drive Suite 100 Huntsville, AL 35802

Telephone number: 256-882-3605 Fax: 256-880-1272

TO RELEASE INFORMATION FROM MY MEDICAL ROCORDS TO:
Name of person(s) or organization(s): ____

Address: ______________________________________ email: ________________________________

Telephone number: _____________________________ Fax: _________________________________

HOW TO BE RELEASED: ☐ **Faxed** ☐ **Mailed** ☐ **Pick up** (*please allow up to 7-14 days for release)*

INFORMATION TO BE RELEASED: *(circle all that apply)*
All Urology Specialists records   X-rays/Ultrasound Reports   Consultation Reports
Biopsy Results   Laboratory/Pathology   Other (please specify)

Purpose: ____

The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care. I may revoke this authorization at any time by notifying Urology Specialists in writing to 4704 Whitesburg Drive, Suite 100, Huntsville, AL 35802 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Urology Specialists before Urology Specialists received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 366th day of the signing. If neither federal nor Alabama privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Alabama privacy law. I may inspect and receive a copy (Alabama law establishes fees for copy charges of medical records) of the information to be used and disclosed pursuant to this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from Urology Specialists. If I elect to have my records sent via email, I acknowledge Urology Specialists does not warranty any security once the email leaves our system. Email is not a secure mode of transmitting protected health information.

_______________________________________   _______________________________________

Signature of patient or Personal Representative   Printed name of patient

_______________________________________   _______________________________________

Printed name of Personal Representative *(if applicable)*   Date