UROLOGY ASSOCIATES of Green Bay

720 SOUTH VAN BUREN STREET SUITE 301, GREEN BAY, WI 54301 PH. (920) 433-9400 FAX (920) 433-9409

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT:

_____ Name, Last, First, MI

_____ Address

_____ Date of Birth

_____ City, State, Zip

(____) _____ Phone #

AUTHORIZES:

_____ Name

_____ Street Address

_____ City, State, Zip

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

_____ Name

_____ Street Address

(____)_____ Phone #

_____ City, State, Zip

(____)_____ Fax #

TYPE OF INFORMATION TO BE USED OR DISCLOSED FROM _____TO_____: (Check all that apply)
Mo/Yr Mo/Yr

___ Medical history, exam, reports
___ Operation reports
___ Treatment or Tests
___ X-ray reports
___ Hospital records, including reports
___ Copies of all other reports
___ Laboratory reports
___ Prescriptions
___ Consultations
___ HIV test results
___ Mental Health records
___ Alcohol, Drug abuse reports

PURPOSE OR NEED FOR DISCLOSURE: _____

This authorization will remain in effect until: _____

This authorization will be in effect for medical records until I revoke it or the Authorization expires. I understand that I may withdraw this authorization at any time by providing my written notification. I also understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_____ **Signature of Patient**
(If signed by other patient, state relationship)

_____ **Date**

This release is executed in conformity with Wisconsin Stats. 146.81 - .83, 51.30, 146.025.
A photocopy of this release is as valid as the original.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **You have a right to receive a copy of this Authorization;**
- **You have the right to refuse to sign this Authorization**-We cannot condition our provision of services or treatment to you on your decision to sign this Authorization.
- **You have the right to withdraw this Authorization**-You can withdraw this Authorization by providing a written statement of withdrawal. I am aware that my withdrawal will not be effective until received by Urology Associates of Green Bay and will not be effective regarding the uses and/or disclosures of my health information that Urology Associates of Green Bay has made prior to receipt of my withdrawal statement.
- **You have the right to inspect or copy the health information to be used or disclosed;**
- **HIV test results:** I understand my HIV test results may be released w/o authorization to persons/organizations that have access under State law.
- **I understand that Urology Associates of Green Bay may charge a reasonable, cost**-based fee for copying and preparation. I finally understand that the fee must be paid in full prior to my receiving the medical records.