New York Urologic
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General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: _____or other person/entity (specifically describe) _____to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Other (describe specifically)
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Pharmacy/prescription records

_____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s):
_____

Please send the records listed above to (use additional sheets if necessary):

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Name: _____
Address: _____
_____
Phone _____
Fax: _____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For payment/insurance
- ☐ Other: -
- ☐ For my health care
- ☐ For employment purposes

_____

This authorization shall expire no later than: ___/___/___ or upon the following event _____
(whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical

records.I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ Signature of patient (or patient's personal representative)	_____ Date
_____ Printed name of patient representative patient, *(i.e parent,*	_____ Representative's authority to sign for *guardian, power of attorney for healthcare, executor)*