



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>i.e parent,</i>	_____ Representative's authority to sign for <i>guardian, power of attorney for healthcare, executor)</i>