NORTHEAST UROLOGIC SURGERY, PC
AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for **all** Authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below:

NAME:____ **DATE OF BIRTH:**__________________

PLEASE IDENTIFY THOSE PERSONS/ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE YOUR INFORMATION:

PLEASE IDENTIFY THOSE PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE YOUR INFORMATION

PLEASE PROVIDE A SPECIFIC DESCRIPTION OF YOUR INFOMRATION TO BE USED OR DISCLOSED INCLUDING DATES

PLEASE PROVIDE A REASON FOR THE REQUESTED USE OR DISCLOSURE OF YOUR INFORMATION (i.e., for life insurance, disability, etc)

I understand that I may revoke this authorization at any time by notifying Northeast Urologic Surgery, P.C. in writing; however, any revocation does not affect any actions taken by Northeast Urologic Surgery, P.C. before Northeast Urologic Surgery, PC received my written revocation.

Initials___________________

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and my no longer be protected by federal privacy regulations or other applicable state or federal laws.

Initials___________________

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Initials___________________

I understand that this authorization will expire on:____

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization.

Signature____

Authorization for sensitive patient medical information will require a second signature:

I authorize Northeast Urologic Surgery, PC to release the following sensitive information :

ABORTION HIV TESTING SEXUAL ASSAULT MENTAL HEALTH VISITS AIDS/ARC
VENEREAL DISEASE INVERTILITY STUDIES DRUG/ALCOHOL ABUSE

TO THE FOLLOWING:

Authorization to release sensitive information will expire on :____

____
SIGNATURE OF PATIENT OR LEGAL PERSONAL REPRESENTATIVE DATE

Print name:____

Relationship to patient:____