The Urology Clinic of Utah Valley

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

1. I authorize The Urology Clinic of Utah Valley, LLC to release my information to:

   Name: _____

   Address: _____

   Phone/Fax: _____

2. The following information may be released (MUST BE SPECIFIC :)

_____

_____

_____

3. This information is being requested for the following purpose(s):

_____

_____

I hereby authorize the release of my protected health information as described and understand and acknowledge the following:

- I may refuse to sign this authorization; however, I do understand that my records will not be released if I do not sign it.
- My treatment or billing for treatment by The Urology Clinic of Utah Valley will not be affected by my decision to sign or not sign this authorization.
- If the organization or person authorized to receive this information is not required to comply with federal privacy regulations (such as an employer or a school), the released information could be re-disclosed by them and would no longer be protected.
- I may inspect or copy the protected health information requested in this authorization as permitted by federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to The Urology Clinic of Utah Valley's records custodian. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact the records custodian who will provide me with more information about this authorization or about our privacy practices.

I certify that I have read, signed, and received a copy of this authorization.

_____ _____

Signature of Patient (or responsible party) Date

_____

Relationship to Patient