UROLOGIC SURGERY
Dr. Genri Pinkhasov MD,FACS of NWI

Authorization for Release of Medical Records

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations

Patient's Last Name:	Patient's First Name:
DOB:	Today's Date:
Address:	
Telephone #:	Email:

I authorize the use and disclosure of health information about me as described below:

Facility authorized to release my health information	
Name:	Telephone #:
Address:	Fax #:
Facility or individual(s) authorized to receive my health information	
Name:	Telephone #:
Address:	Fax #:

Health Information that may be used/disclosed is limited to the following:

__Discharge Summary __History and Physical __Consultation(s) __Progress Notes

__Laboratory Tests __Pathology Report __Operative Note(s) __Imaging/Xray Films __Entire Record

Sensitive Information:

__Alcohol Abuse __Drug Abuse __Communicable Diseases (including HIV) __Genetic Testing

__Psychiatric/Behavioral Diagnosis __Other (*Specify*) ____

Health Information that may be used/disclosed is limited to the following periods of healthcare:

From (date):___________________________________ To (date):_______________________________________

Health Information to be released to the above named facility/individual is to be used/disclosed for the following purpose(s):

__Treatment/Consultation __At Request of Patient __Research __Marketing ___Billing or Claims Payment

__At Request of Employer Other____

CONFIDENTIALITY POLICY _(PLEASE READ BEFORE SIGNING)_

Medical records, which are part of “Health Information,” are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase “medical records” includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing. I understand this authorization is voluntary and may refuse to sign it. I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with HIPAA privacy regulations.

Patient/Guardian Name:	Date:
Patient/Guardian Signature:	
Relationship to Patient:	
Witness Signature:	