UROLOGY CENTER OF COLUMBUS, L.L.C.

Authorization for Release of Protected Health Information

_____

Patient Full Name **Address** **City** **State** **Zip**

_____ _____

Date of Birth **Daytime Phone**

I am requesting records for: ☐ Myself ☐ Inspection ☐ Changing Physicians
☐ Consultation ☐ School ☐ Legal ☐ Other _____

You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. To submit a request, please fill in the following information:
☐ View on site. ☐ Pick up ☐ Please mail the copies I requested to the address above.

I hereby authorize Urology Center of Columbus to discuss and/or release a copy of my health information to the person/organization specified below:

Person/Agency/Organization_____

- ☐ Will pick-up
- ☐ Mail to address _____
- ☐ Fax to: _____ ☐ Verbal Communication

Information to be released (please be specific and enter date of service if known):

Dates of Information to be Disclosed: From _____ to _____
☐ Entire medical record ☐ Clinic Notes ☐ Pathology Reports ☐ x-ray reports
☐ Medication Records ☐ Itemized Bill ☐ Other _____

Limitations: _____

I understand that this authorization is effective immediately and will remain in effect until:

- ☐ ____/_____/_____ or
- ☐ No expiration, unless revoked or terminated by the patient or the patient's personal/legal representative.

I understand that I have a right to receive a copy of this authorization. I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and UCC will not condition my treatment on my providing authorization for the requested use or disclosure. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations. I understand that I may inspect or copy the information to be disclosed, for a reasonable charge.

Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial. We will complete our review of your request within 7-10 business days and contact you either by phone or writing to inspect or pick up a copy of your records.

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal/Legal Representative Relationship to the Patient

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Office Use Only

Request completed by: _____ Date _____

- ☐ We hereby accept this request.
- ☐ We hereby deny this request.

Comments: _____