Authorization to Obtain Protected Health Information

<table>
<tr><td>Patient Name:</td><td>Date of Birth:</td></tr>
<tr><td>Address:</td><td>Telephone #:</td></tr>
<tr><td colspan="2">If Requested by Personal/ Legal Representative (Name & Relationship)</td></tr>
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Purpose of the requested access or disclosure: ☐ Changing Physicians ☐ Consultation
☐ Continuity of Care ☐ Other ____

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

☐ Entire medical record, excluding ____
☐ Medical Record Abstract (e.g. H&P, Operative Report, discharge summary, consults, labs, x-rays, pathology)
☐ Clinic Notes ☐ Pathology Reports ☐ x-ray reports ☐ Medication Records
☐ Itemized Bill ☐ Other ____

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.

____ ____________________________
Signature of Patient Date

____ ____________________________
Signature of Personal/Legal Representative Relationship to the Patient

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