EAST VALLEY
UROLOGY CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	☐ M ☐ F	DATE OF BIRTH
ADDRESS	CITY/STATE/ZIP CODE	
PHONE (HOME)	PHONE (WORK)	

I hereby authorize **EAST VALLEY UROLOGY CENTER** to:

☐ **OBTAIN** ☐ **RELEASE** a copy of my medical records ☐ **TO** ☐ **FROM** the following:

FACILITY: _____ ATTENTION: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE: _____ FAX:_____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse and mental health diagnosis and treatment. I ☐ **DO** ☐ **DO NOT** authorize the release of this type of information.

RECORDS TO BE RELEASED			
☐	Complete Information	☐	Operative Report(s)
☐	Discharge Summary	☐	Emergency Room Report(s)
☐	Hospital Consultation(s)	☐	Diagnostic Imaging Studies
☐	History & Physical	☐	Labs / Pathology Reports

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for the disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization
- This authorization will be good for 1 year from the date it is signed.

_____

Patient or Personal Representative's Signature Date

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