

---

---

# N.E.O. Urology Associates, Inc.

7430 Southern Blvd.  
Boardman, Ohio 44512  
(330)729-9214  
(330)729-9217  
[info@neourology.com](mailto:info@neourology.com)

6262 Mahoning Ave. Ste. C  
Austintown, Ohio 44515  
(330)779-6851  
(330)270-3484  
[info@neourology.com](mailto:info@neourology.com)

[www.neourology.com](http://www.neourology.com)

---

Richard A. Memo, M.D. F.A.C.S.

Robert R. Ricchiuti, M.D. F.A.C.S.

Vincent S. Ricchiuti, M.D. F.A.C.S.

Daniel J. Ricchiuti M.D. F.A.C.S.

Mark A. Memo D.O. F.A.C.S.

David W. Drevna, M.D.

Cortney Birchak, CNP

## Patient Authorization to Release Protected Health Information

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Release From: \_\_\_\_\_ Release To: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

Description of the information to be used or disclosed: \_\_\_\_\_

---

I understand that this may include information relating to:

- Acquired immunodeficiency syndrome (AIDS) or HIV infection
- Behavioral Health Services/psychiatric care
- Treatment for alcohol and/or drug abuse

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health care information may be used or disclosed to carry out treatment, payment, or healthcare opportunities.

- I understand that N.E.O. Urology Associates, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing to the Privacy Officer, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

- I understand that the information used for disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- Without written revocation, this consent expires after one year.

Signature of the Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If representation, relationship to Patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_