N.E.O. Urology

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____

Release From: _____ Fax Number: _____

Release To: _____ Fax Number: _____

Description of 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 purposed, and
- The right to request restrictions as to how my healthcare 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 Office Manager, 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, **N.E.O. Urology Associates, Inc.** 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 my be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Without written revocation, this consent expires after one year.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship _____

Signature of Witness: _____ Date: _____