SUBURBAN UROLOGIC ASSOCIATES
2580 Haymaker Road, #401, Monroeville, PA 15146
412-372-6330 FAX#: 412-372-3319

Authorization for Release of Protected Health Information

PLEASE PRINT *AND FILL OUT COMPLETELY*

Patient Name: _____ Birthdate: _____
Last name First Name M I

Address: _____
Street

_____
City State Zip

I _____ have been a patient at Suburban Urologic Associates *OR*
I _____ am the above patient's authorized representative. I understand that the facility has legally Protected Health Information about the above patient. I understand that signing or not signing this form will not affect treatment I receive in any way. I hereby authorize:

_____
(Name of Physician, Individual, Facility, Agency, School, or Entity)

To Release My Information To: _____
Address: _____

_____

Phone: (_____) _____ Fax: (_____) _____

The following information or copies of: **(Place a check by types of records desired)**

____ Hospital documents (H&P, op notes, discharge summaries, etc.)
____ Office notes
____ Lab results / Pathology results
____ Radiology results
____ The entire medical record which INCLUDES HIV-Related information.
____ The entire medical record INCLUDING mental health, drug or alcohol treatment.
____ Entire medical record EXCLUDING HIV- Related, mental health, drug or alcohol treatment.
____ Billing
____ Other (Specify): _____

From (date): _____ To (date): _____

Reason for Request: ____ Continuing treatment ____ Second Opinion ____ Insurance ____ Employer
____ Legal ____ Study/Research ____ Other _____
____ I do not wish to disclose the reason

This authorization will expire in 6 months or: _____

I understand that this authorization is subject to revocation at any time, except to the extent that Suburban Urologic Associates has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer.

_____ _____
Patient or Representative Signature Date