SUBURBAN UROLOGIC ASSOCIATES 2790 Mosside Blvd., #G110 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: Last name City Street City Address: Street City Aname have been a patient at Suburban Urologic Associa am the above patient's authorized representative. I understand that signing signing this form will not affect treatment I receive in any way. (This information must be filled out completely or records will NOT be forward I hereby authorize: Fax: (Name of Physician, Individual, Facility, Agency, School, or Entity, address and phone To Release My Information To: Address: Phone: () Hospital documents (H&P, op notes, discharge summaries, etc.) Office notes Lab results / Pathology results Radiology 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):	
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Other (Specify):	
From (date): To (date):	
Reason for Request: Continuing treatment Second Opinion Insurance Employee	lover
I do not wish to disclose the reason	
his authorization will expire in 6 months or:	
understand that this authorization is subject to revocation at any time, except to the extent that Suburban Urologic ssociates has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be conside alid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above us toke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose informat I have authorized them to receive.	red
Patient or Representative Signature Date	

Date