

**Patient Authorization to Use or Disclose Protected Health Information**

I, \_\_\_\_\_, (DOB) \_\_\_\_\_ understand Las Vegas Urology is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Las Vegas Urology, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

- The patient’s entire medical record  
(NOTE: This requires an explanation why the entire record may be disclosed).
  
- The patient’s demographic information (*check all that apply*):  
 Name       Address       State/Zip Code only       Telephone  
 Age    Gender       Race       Other: \_\_\_\_\_
  
- Medical Data/Information as related to:  
 Specific condition(s): \_\_\_\_\_  
 Specific professional service(s): \_\_\_\_\_  
 Specific medication(s): \_\_\_\_\_  
 Other: \_\_\_\_\_
  
- Other: \_\_\_\_\_  
\_\_\_\_\_

Purpose(s) of the information:  
\_\_\_\_\_  
\_\_\_\_\_

[ ] (Check if applicable) This authorization permits Las Vegas Urology to send the protected health information ONLY to this address or fax number:

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Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Las Vegas Urology must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Las Vegas Urology will accept written revocations of this authorization via:

Certified U.S. mail

Facsimile at this number: (702) 233-4799

ALL revocations must be sent to Las Vegas Urology to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on \_\_\_\_\_. After this date, Las Vegas Urology can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

Authorization added to the patient's medical record on \_\_\_\_\_.

Authorization verified by \_\_\_\_\_ on \_\_\_\_\_.