Urological Associates of Bridgeport, P.C.

160 Hawley Lane, Suite 002
Trumbull, CT 06611
Tel: 203-375-3456
Attn: Medical Records
Fax: 203-375-4456

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME: _____ **DATE OF BIRTH:** ____/___/____ **PHONE: (cell)** _____

_____ _____ _____ _____ **(home)** _____
Address **City** **State** **Zip**

FROM: _____ **RELEASE TO:** _____
Name Name

ADDRESS: _____ ADDRESS: _____
_____ _____
FAX: _____ FAX: _____
PHONE: _____ PHONE: _____

REASON FOR RELEASE: ☐ Further Medical Care ☐ Attorney/Litigation ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability
☐ Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:
☐ Entire Record
☐ Lab results ONLY
☐ Only the period of events from _____/_____/_____ to _____/_____/_____
☐ Only information related to (*specify*) _____
_____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ **Substance Abuse Treatment Information**
☐ **HIV related information, including AIDS related testing**
☐ **Behavioral/Psychiatric/Mental Health services (other than psychotherapy notes)**
☐ **Sexually transmitted diseases**
☐ **Psychotherapy notes (*by checking this box, I am waiving any psychotherapist-patient privilege*)**

IF RECORDS ARE BEING PICKED UP IN PERSON OTHER THAN BY YOURSELF, PLEASE STATE WHO YOU ARE GIVING PERMISSION TO DO SO: _____
NAME & RELATIONSHIP

PHOTO ID IS REQUIRED TO PICK UP RECORDS

THE ABOVE MENTIONED PROTECTED HEALTH IMFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE PARTY RECEIVING THE INFORMATION AND MAY NO LONGER BE PROTECTED BY FEDERAL AND STATE PRIVACY RULES. BY SIGNING THIS FORM, YOU AUTHORIZE **UROLOGICAL ASSOCIATES OF BRIDGEPORT, PC** TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU FOR THE REASONS MENTIONED ABOVE. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR AUTHORIZATION. SUBMIT YOUR REVOCATION TO THE PRIVACY OFFICER OF THE PRACTICE. **THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM DATE OF SIGNATURE UNLESS OTHERWISE SPECIFIED**.

THIS AUTHORIZATION IS SIGNED BY: _____ _____
PATIENT NAME OR REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT (* indicates that legal documentation is required): ☐ Self ☐ Parent ☐ Guardian* ☐ Conservator/Executor*
☐ Power of Attorney* ☐ Family *(specify)*: _____ ☐ Other *(specify)*: _____

OFFICE USE ONLY:
Requester ID verified by *(employee name)*: _____ Date: _____

Verified Using *(indicate form of ID)*: _____ ID Number: _____