Urology birmingham
CENTERS OF ALABAMA, P.C.
3485 Independence Drive • Homewood, Alabama 35209
(205) 930-0920

Authorization to Disclose Health Information

Patient Name: _____ Soc. Sec. #: _____

Date of Birth _____

1. I authorize Urology Centers of Alabama, P.C. to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as followed: (include dates where appropriate)

- ❑ Entire record
- ❑ Problem list
- ❑ Medication list
- ❑ List of allergies
- ❑ Immunization record
- ❑ Most recent history and physical
- ❑ _____
- ❑ _____
- ❑ _____

- ❑ Laboratory results: from (date) _____ to (date) _____
- ❑ Most recent discharge summary
- ❑ X-ray & imaging reports: from (date) _____ to (date) _____
- ❑ Consultation reports: from (doctors' names) _____
  _____
- ❑ Patient Account Statement/Billing Records

❑Other: _____

3. I understand the information in my health record may include information relating to Sexually Transmitted Disease (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

For the purpose: _____

❑ At the request of the individual

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the privacy officer. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the federal Register Rules and Regulations. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the privacy officer.

Patient Signature: _____ Date: _____