Affiliated UROLOGISTS

*Stephen Ponas, MD  Al Borhan, MD, FACS  Daniel C. Jaffee, MD, FPRMS  Daniel E. Cooper, MD, MPH*
*Kevin S. Art, MD  Robert Lipson, MD  Christopher Martin, MD  Keaton Marsh, PA-C*

# HIPAA AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

I, [**Patient Name**:]_____, [**Date of Birth**:]_____ authorize Affiliated Urologists, a division of Arizona Oncology Associates to **use and disclose** my medical information to:

Organization Name: _____Attention: _____
Address: _____City_____ State_____ Zip_____
Phone: _____ Fax: _____

**INFORMATION TO BE RELEASED:**

_____ Provider Office Notes_____ Surgical Reports _____Progress or Discharge Notes_____ Immunizations
_____ Tests and Results _____ Allergy Records _____ Hospital Records Including Reports
_____ Prescriptions _____ Radiology Reports _____Consultations _____Laboratory Reports (Including Pathology)
_____ **Entire Record** _____ Other (Specify):_____

**In addition, I specifically authorize the release of records pertaining to:**

_____ Mental Health _____ Alcohol and Drug Abuse _____ HIV-related information____Other Communicable Diseases_____ Genetic information _____ Developmental Disabilities _____ Other (Specify):_____

**For The Following Date(s):** _____ to _____ ****OR**** □ all past, present and future periods

**HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:**

**Right to Revoke Authorization.** I understand that I have the right to revoke this authorization, except to the extent that Affiliated Urologists has already used or disclosed my medical information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to Arizona Oncology medical records staff.

**My Medical Information May Be Re-Disclosed.** I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my medical information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

**Right to Inspect and Copy My Medical Information.** I understand that I have the right to inspect and copy my medical information in Arizona Oncology records. I understand that to inspect and copy medical information, I must submit my request in writing to Affiliated Urologists medical records staff. If I request a copy of the information, I understand that Affiliated Urologists may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that Affiliated Urologist may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed in certain circumstances.

**I Am Not Required to Sign this Authorization.** I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment at Affiliated Urologists. However, I also acknowledge that I have agreed to sign this authorization.

**Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

**EXPIRATION DATE:**

This authorization will remain in effect until the following date (or event): _____. If no date or event is specified, this authorization shall expire one year from the date this form is executed as listed below.

**Signature of Patient**:_____**Date:**_____

**Signature of Legal Representative:**_____**Date:**_____

If signed by a Legal Representative, **include documentation of legal authority** and complete the following:

1. The Individual is: □ a minor □ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent* □ legal guardian □ next of kin/executor of deceased □ activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order*