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
Dr._____- Fax: _____to **use and disclose** my medical information to:

Organization Name: **Affiliated Urologists, Ltd** Attention: **Medical Records**
Phone: **602-264-0608** Fax: **602-234-0417**

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