NORTH DALLAS UROLOGY ASSOCIATES

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:_____

Patient Name:_____

Date Of Birth:_____

Description of the specific information to be used or disclosed: (Please check one of the following:)

☐ **All information**

Or Specific information like the following (Please list below)

☐ **pick up patient's medical records**
☐ **cancel, reschedule, make appointments for patient**
☐ **call to get patient's results**
☐ **pick up patient's medicine/samples**

Write names of people we can give out information to and the relationship to them. If you *DO NOT* want us to release any information to anybody, just cross out the page.

Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____

I understand that:

- **I may inspect or copy the protected health information to be used or disclosed.**
- **I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.**
- **Information used or disclosed pursuant to the Authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA.**

Patient Signature:_____ **Date:**_____