Authorization to Disclose Private Healthcare Information

Name of Patient:_____ DOB:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work/Cell:_____

I authorize: **Alaskan Interior Urology, LLC. John W. Huffer, M.D.**

To disclose my private healthcare information as described below to:

Name:_____

City/State/Zip:_____ Fax:_____

The type and amount of information to be used/disclosed is as follows (please check all that apply):

[ ] Hospital Medical Records [ ] History & Physical/consultations/ Progress notes [ ] Billing Records

[ ] Radiology/Imaging Reports and/or Radiology Films [ ] Laboratory/Pathology Reports [ ] Other

[ ] Alcohol/Drug Records and/or HIV test results [ ] Complete Medical Records

Disclosure purpose:_____

Date of Services:_____ Form PCM:_____

I authorize the release of information in my health records which may include information relating to:

Sexually Transmitted Diseases, HIV/AIDS—related info (CGS 19A-585(a)), Mental Health Services (CGS 52-146(d)), Alcohol/Substance Abuse (42CFR 2.1-2.67) **YES** **NO**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. Additional information regarding the individual's rights to revoke an authorization is found in Tanana Valley Urology LLC's Notice of Privacy Practices.

This authorization expires on the following date:_____

I understand that authorizing disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment of services, enrollment or eligibility for benefits from Tanana Valley Urology, LLC. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand Tanana Valley Urology LLC may charge a processing fee for copying records.

If I have any questions about disclosure of my health information, I can contact the Medical Records Department at Tanana Valley Urology.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient or Patient's Representative

_____ _____

Relationship to Patient ******OR****** ⇨ Legal Authority (Attach Documentation)