COLUMBIA UROLOGICAL ASSOCIATES, P.A.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Provider Name: _____Address: _____
_____Phone:_____Fax:_____
Patient's Full Name at Time of Treatment_____
Patient's Address_____
Date of Birth_____ Social Security Number_____
Dates of Treatment_____ Purpose of Release:_____

I authorize the above named Provider to release my health information to the following Provider: _____

Information to be released: (Please check all that apply)

- ☐ Laboratory Reports
- ☐ Medical records (office notes and hospital notes)
- ☐ EKG/Radiology reports
- ☐ Pathology reports
- ☐ Diagnostic tests
- ☐ .

1. **I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable disease, this information will be released as part of my record.**
2. **I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.**
3. **I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.**
4. **I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.**
5. **I understand that this authorization will expire in 90 days after signed unless otherwise specified here _____.**

_____ _____
Signature of Patient or Authorized Person Date

Request for Records sent on_____ Verification completed by_____
Fax Number: (803) 931-8000
Authorization for release protected health information