# Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____
SS #_____**C**hart#_____**□Pick up □Mail □ Fax**
Verified By**:**_____Entered in Computer**:**_____ **□ By Telephone**

**Columbia Urological Associates, P.A.** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| **Entity to Receive Information.**<br>Check each person/entity that you approve to receive information. (When listing people approved to receive information, please limit to (2) two.) | **Description of information to be released.**<br>Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ❑ Voice Mail/Answering Machine<br>*(If you would like test results or appointment information left on your voice mail or answering machine, please check the appropriate boxes on the right)* | ❑ Results of lab tests/x-rays<br>❑ Appointment Information<br>❑ Other_____ |
| ❑ Give information to employer<br>❑ Give information to school<br>*(If you would like information regarding absences to be given to your employer or school, please check the box on the right. If you choose not to do this, your approval will be necessary in each instance before any absence information will be released.)* | ❑ Appointment absentee information |
| ❑ Spouse<br>*(Please check any of the boxes on the right if you wish for your spouse to routinely have access to this information.* ***If you do want your spouse to have access, please legibly write their name below.)***<br>_____ | ❑ Financial<br>❑ Appointment Information<br>❑ Medical as follows:_____ |
| ❑ Parent (provide name)_____<br>*(Please check any of the boxes on the right if you wish for your parent to routinely have access to this information. If you do want your parent to have access, please legibly write their name below.)*<br>_____ | ❑ Financial<br>❑ Appointment Information<br>❑ Medical as follows:_____ |

| | |
|---|---|
| ❑ Other (provide name) _____<br>_____<br>*(If you want anyone other than a spouse or parent to have access to your Private Health Information, please check the appropriate boxes to the right and legibly write their name and relationship to you on the line below.*<br>_____<br>_____ | ❑ Financial<br>❑ Appointment Information<br>❑ Medical as follows _____ |

**Other Directives:**

**Rights of the Patient**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Privacy Officer/Administrator. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____

**Signature of Patient or Personal Representative**

Description of Personal Representative's Authority (attach necessary documentation) _____

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge, by signature, that I have received a copy of Columbia Urological Associates' Notice of Privacy Practices. It has been issued and is considered effective on the date noted below.

| | |
|---|---|
| _____ | _____ |
| Signature of Patient/Representative and Relationship to Patient | Date |
| _____ | _____ |
| Signature of Practice Representative | Date |