

**NORTHEAST UROLOGIC SURGERY, PC  
AUTHORIZATION FOR RELEASE OF INFORMATION**

**SECTION A:** Must be completed for **all** Authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below:

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

PLEASE IDENTIFY THOSE PERSONS/ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE YOUR INFORMATION:

\_\_\_\_\_

PLEASE IDENTIFY THOSE PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE YOUR INFORMATION

\_\_\_\_\_

PLEASE PROVIDE A SPECIFIC DESCRIPTION OF YOUR INFORMATION TO BE USED OR DISCLOSED INCLUDING DATES

\_\_\_\_\_

PLEASE PROVIDE A REASON FOR THE REQUESTED USE OR DISCLOSURE OF YOUR INFORMATION (i.e., for life insurance, disability, etc)

\_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying Northeast Urologic Surgery, P.C. in writing; however, any revocation does not affect any actions taken by Northeast Urologic Surgery, P.C. before Northeast Urologic Surgery, PC received my written revocation.

Initials \_\_\_\_\_

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and my no longer be protected by federal privacy regulations or other applicable state or federal laws.

Initials \_\_\_\_\_

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Initials \_\_\_\_\_

I understand that this authorization will expire on: \_\_\_\_\_

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization.

Signature \_\_\_\_\_

**Authorization for sensitive patient medical information will require a second signature:**

**I authorize Northeast Urologic Surgery, PC to release the following sensitive information :**

**ABORTION      HIV TESTING      SEXUAL ASSAULT      MENTAL HEALTH VISITS      AIDS/ARC  
VENEREAL DISEASE      INVERTILITY STUDIES      DRUG/ALCOHOL ABUSE**

**TO THE FOLLOWING:**

\_\_\_\_\_

**Authorization to release sensitive information will expire on :** \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR LEGAL PERSONAL REPRESENTATIVE**

\_\_\_\_\_  
**DATE**

**Print name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_