

This authorization, if signed will authorize New York Urology Specialists to use and disclosure certain protected health information that is possesses about the person named below. This authorization is voluntary; I hereby authorize New York Urology Specialists to disclose protected health information (Medical Records) relating to:

Patient Name: _____

Patient Date of Birth: _____

Please send and release the following information

Entire Medical Record

OR

Only records pertaining to the following dates of service

From: _____ to: _____

OR

Only Specified Documents: (Please indicate below.)

I understand that the released information may pertain information relating to:

- Acquired immunodeficiency syndrome (AIDS)
- Treatment for drug or alcohol abuse
- Sexually transmitted diseases

Please send my records to the following parties:

Name: _____

Address: _____

City, State, and Zip Code: _____

Fax Number: _____

I understand as a patient, I have the right to revoke this authorization at any time by notifying the **New York Urology Specialists** Privacy Officer. This authorization is valid for one year from the date it has been signed.

Signature of Patient or patient representative:

Signature

Date

Please Print the Name of the Patient Representative (if any)