New York Urology Specialists

Release of Medical Records from New York Urology Specialists to another party

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)