North DFW Urology, LLP

Authorization Form

For Release of Protected Health Information

Patient Name:_____ **Date of Birth:** _____

By signing this form, I authorize you to use and disclose the protected health information described below.

___Chart Notes ___Diagnostic Images ___Clinical Procedures

___Surgeries ___Medication History **OR** ____ **ALL OF THE ABOVE**

Release my protected health information to the following person(s)(**SOMEONE OTHER THAN YOUR DOCTOR**)/entity:

Name: _____

Street: _____

City: _____State: _____Zip: _____

The reasons or purposes for this release of information are as follows:_____

_____

This authorization shall be in force and effective until the following event and/or date:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to:

North DFW Urology, LLP
1601 Lancaster # 170
Grapevine, TX 76051

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself .I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Personal Representative **Date**

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review North DFW Urology, LLP Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document by requesting a copy from the receptionist.

_____ Date: _____

Signature of Patient or Personal Representative

_____

Printed Name

(Internal use only: Date copy given _____ by whom _____)