Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Patient Phone Number: _____

University Urology
Scott Caesar, M.D.
Phone number (239) 458-1196
Fax number (239) 458-1345

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION.

1. **I authorize the healthcare provider, individual, or organization to DISCLOSE the above named individual's health information for the purpose of providing continuing care to the patient:**

   Name: _____
   Address: _____
   Phone: _____ Fax: _____

The type and amount of information to be used or disclosed is as follows:

_____ Physician Visit Notes
_____ Radiology Reports
_____ Radiology: CT - MRI
_____ Radiology: Bone Scan
_____ Laboratory Results
_____ Original Consults – History - Physical
_____ Surgery/Pathology
_____ Work Release requested
_____ OTHER: _____

The time frame for the disclosure information is: from (date) _____ through (date)_____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature

3. I understand that authorizing to obtain this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the 21st Century Oncology Privacy Officer at 1.866.679.8944.

_____	_____	_____
Date	Patient Signature or Legal Representative	Witness

If signed by legal representative, state the relationship to the patient: _____

THIS RELEASE OF INFORMATION IS ACTIVE FOR A PERIOD OF SIX (6) MONTHS.
DOCUMENT ON ACCOUNTABILITY OF DISCLOSURE LOG ACCESS TO RECORD.