SOUTHWEST FLORIDA UROLOGIC ASSOCIATES

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual information as described below

Patient name	Date of Birth	Medical Records Number
Address (street, city, state, zip)	Fax #	Phone #

The following individual or organization is authorized to make the disclosure:
_____ 21st Century Oncology
_____ Other (please Specify :_______________________________________)

This information may be disclosed to and to and used by the following individual or organization:
_____ 21st Century Oncology
_____ Other (please Specify :_______________________________________)

Purpose of request: _______________________________________

The following information generated by our physician is to be disclosed:

___ Consultation Reports
___ Office Dictation
___ Pathology Reports
___ Complete Record
___ Other: _______________________________________
___ Surgery Report
___ Laboratory Results
___ Radiology Reports
___ Diagnostic Films
___ Pathology slides
___ CDs
___ Films

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse._______________________________________

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the Health information Management Department. I understand that the revocation will not apply to information that has already been released based on this authorization.
Initial:_______________ Expiration Date:_______________ (one year)_______________

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524

REQUEST DATE: _______________ RESOLUTION DATE: _______________ INITIAL: __________
RECORDS: ____ GIVEN TO PATIENT: CAPE / W.H./ LEHIGH ____ FAXED ____ MAILED

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_______________________________________ DATE: _______________
PLEASE PRINT BELOW:

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** please see attached requisition for slides, CDs, or films.**