

UROLOGY ASSOCIATES OF DANBURY, P.C.

ADULT & PEDIATRIC UROLOGY

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed:

The information covered by this authorization includes: _____ All Relevant Medical Information
_____ Office Visits _____ Lab Results _____ X-Rays _____ MD Notes/Letters

Information listed above will be used or disclosed by Urology Associates of Danbury, P.C.

Information described above may be disclosed to: (Please choose individual and provide name.)

_____ Name of Person/Organization	_____ Relationship to Patient
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Expiration Date of Authorization:

This authorization is effective through _____, unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to Urology Associates of Danbury, P.C. You should contact the office's Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Signature of Patient

Print Name of Patient

Date

Signature of Patient Representative

Relationship to Patient

File:authorization

