UROLOGY

Michael P. Zahalsky, MD - Mini Varghese, MD - Christopher P. Hollowell, MD - Michael Tyler, MD
Melissa Marchand, PA-C - Monika Kulik, PA-C - Linda Calderon, PA-C
954-714-8200 Phone 954-840-2626 Fax
www.zurology.com

HIPAA Authorization

PATIENT'S FULL NAME_____

SOC SEC #_____ BIRTHDATE_____ PHONE _____ E-MAIL_____

STREET _____STATE ___ ZIP _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) _____ will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).
If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device. please complete the following:

I authorize _____ to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Z Urology if this authorization information changes.

It is ok to leave confidential medical information for me on my:
[] Home telephone/message _____
[] Work telephone _____
[] Mobile telephone _____
[] Home Facsimile _____
[] Work Facsimile _____

It is okay to give confidential medical information to my:
(List specific names)
[] Spouse _____
[] Parent(s) _____
[] Son/daughter _____
[] Brother/Sister _____
[] Other (name required) _____

I authorize this information to be disclosed in the following ways:
[] Written/photocopy/paper _____
[] Verbal _____
[] Facsimile _____

Dates of treatment: From _____ to:_____

Specific description of the protected health information that I authorize for disclosure
(Authorization to disclose psychotherapy notes must be separate):
[] Progress notes
[] X-ray films or other images
[] Radiology reports
[] Operative reports
[] Discharge summary
[] Laboratory reports
[] Photographs/videotapes
[] Records from other facilities
[] Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
[] Other

I give specific authorization to disclose the following information:
[] HIV test results
[] Documentation of AIDS diagnosis
[] Psychiatric/mental health treatment records