Comprehensive Urology

Mark J. Makhuli, MD
838 W. Meeting Street, Suite D
Lancaster, SC 29720
T: 803 285-4400
F: 803 285-4404

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an Insurance company or healthcare provider the released information may no longer be protected by federal privacy regulations.

Print Patient Name: _____

Address: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

Information to be released **FROM**:

Facility Name: _____

Address: _____

_____
City State Zip Code

_____
Phone # Fax #

Information to be released **TO:**

Name: _____

Address: _____

_____
City State Zip Code

_____
Phone # Fax #

Dates of Services being requested: **FROM:** _____ **TO:** _____

Circle the specific information to be released: ***OFFICE NOTES / RADIOLOGY REPORTS / X-RAYS***

LABORATORY / PATHOLOGY REPORTS / EKG'S OTHER: _____

Purpose of Disclosure: **Please Circle**

MEDICAL REVIEW / LEGAL REVIEW / INSURANCE REVIEW / PERSONAL USE OTHER: _____

I understand that I have a right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization I understand that revocation will not apply to y insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of information to be used or disclosed.

This authorization is valid 90 days from date of signature:

Print Name: _____ Signature: _____ Date: _____
(Patient / Authorized Representative)

If Authorized Representative, please indicate relationship to patient: _____