PF-3212 Authorization of Disclosure of Protected Health Information By Another Covered Entity for use by Mississippi Urology Clinic, PLLC.

INFORMATION TO BE RELEASED: I hereby authorize: _____

Address: _____

To release/disclose the following confidential/protected health information to Mississippi Urology Clinic, PLLC (please initial the appropriate lines):

_____ Complete Medical Records, or More Specifically:

_____ History and Physical _____ Clinic Notes

_____ Laboratory Tests _____ Xray/Ultrasound Reports

_____ Urodynamics Test Results _____ Inpatient Information

_____ Other (Specify): _____

PURPOSE OF RELEASE: This purpose of the release/disclosure is to transfer records to another provider/covered entity.

TO WHOM RELEASED: The release/disclosure of information is specifically to (circle one):

Mississippi Urology Clinic, PLLC
501 Marshall Street, Suite 301
Jackson, Mississippi 39202
Attn: _____

EXPIRATION DATE OF AUTHORIZATION: This authorization is effective for one year from the date of signing or through ____/____/____ unless revoked or terminated by the patient or patients personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: You may revoke or terminate this authorization by submitting a written revocation to **Mississippi Urology Clinic, PLLC.** You should contact the Private 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

Name of Patient (Print): _____

Date of Birth: _____ Social Security Number: _____

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____