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NORTH SHORE UROGYNECOLOGY
UROGYNECOLOGY & RECONSTRUCTIVE PELVIC SURGERY
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Authorization Form for Release of Confidential Health Information

Patient Name _____ Date of Birth _____

Home Address _____

I hereby authorize North Shore Urogynecology to **release to/receive from**: (circle one)

_____
(Name of Health Care Facility, Physician, Agency, etc)

_____
(Street Address, City, State and Zip Code)

_____
(Phone Number) (Fax Number)

the following information:

- ☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ Operative Notes
- ☐ Other: _____

The purpose(s) of the authorization is (are):

- ☐ Further care/service
- ☐ Personal use
- ☐ Legal purposes
- ☐ Other (specify) _____

I understand that:

- In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- The practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- This authorization is valid until revoked by patient. I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signed: _____
Date: _____

If you are not the patient, please specify your relationship to the patient:

_____