AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Other Name: _____

Address: _____ DOB: _____/_____/_____

_____ Social Security Number: _____-____-_____

_____ Phone: (_____)_____-_____

I hereby authorize (Physician, hospital, or group): _____

_____

_____

To release information to:

Arizona State Urological Institute (ASUI)
2730 S. Val Vista Drive, Building 13, Suite 177
Gilbert, AZ 85295
Phone: (480) 394 - 0200 | Fax: (480) 394 – 0202

[ ] For the following purposes: _____

OR

[ ] All Records

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

[ ] **I DO** authorize the release of this type of information.

[ ] **I DO NOT** authorize the release of this type of information.

I understand that:

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

_____ _____

(Signature of patient or responsible party) (Date)