Gainesville Urology

1240 Jesse Jewell Parkway S.E., Suite 200
Gainesville, Georgia 30501
Phone: 770-532-8438 Fax: 770-535-1785

MRN: _____

WE NEED YOUR PERMISSION TO DISCUSS YOUR MEDICAL CARE OR FINANCES

I. Persons to whom your Medical Information may be disclosed

EXCEPT for other physicians in connection with your ongoing care. Insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies, we cannot release ANY of your medical information to any person or organization (including family members, spouse, etc) unless you list their name below.
You agree that information described above my be disclosed to the following persons or organizations:

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

II. **The purpose and type of information use or disclosure** (cross out if permission not given, otherwise we will understand that you are approving this information to be shared)
1.) Reporting of laboratory or other medical test results
2.) General information (your current medical condition, prognosis, medications, etc.)
3.) Financial details of your billing activity or charges

III. Expiration Date of Authorization
Your permission is effective *(Please select only one)*

_____ Indefinitely

_____ Date Specified ____________ unless revoked or terminated in writing by you or your patient personal representative.

Signature Required on the other side

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IV. You have the Right Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Gainesville Urology. You should contact the Gainesville Urology Privacy Officer in writing to terminate the authorization.

V. Potential for Re-disclosure by another health care provider

Information that is disclosed under this authorization may possibly be disclosed again by the other person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. Gainesville Urology has no control over disclosures by other persons or business entitles with whom we may lawfully share this information.

VI. You may revoke permission to share your medical information

I understand that this authorization will remain in effect until I give written notice to Gainesville Urology PC to remove any of the persons listed above.

_____
Signature of Patient/Resident

_____
Name of Patient / Resident (Print or Type)

_____
Date

_____
Signature of Patient/Resident Representative

_____
Relationship of Patient / Resident Representative to Patient / Resident