Ironwood Urology A division of Ironwood Physicians

Kevin Bigelow, M.D. Desiderio Avila Jr., M.D.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Ironwood Urology to use and/or disclose certain protected health information (PHI) about me to

_____.

Name of entity to receive this information

This authorization permits Ironwood Urology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc) .

_____

_____

The Information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as “at the request of the individual”
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

Expiration date or Defined Event

The Practice will ___/will not____ receive payment or other remuneration from _____ a third party/____ patient in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Ironwood Urology. In fact I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: 4633 East Chandler Blvd. Suite #100, Phoenix, AZ 85048.

Signed by _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____ _____

Print Name of Patient or Legal Guardian Date of Birth Date