IRONWOOD UROLOGY A DIVISION OF IRONWOOD PHYSICIANS PC.

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Authorization to Release Protected Health Information (PHI)

To Ironwood Urology For The Purposes of Continuing Patient Care

Patient Name:_____ Date of Birth:____/_____/_____

Address:_____

City, State, Zip Code:_____

Daytime Telephone Number:_____

I hear by authorize the hospital or medical facility in receipt of this form to disclose the following Protected Health Information pertaining to the above referenced patient to:

Ironwood Urology

- € Please release all pertinent records from the dated of _____ to _____

OR

- € Please release the following information

_____

_____

I understand that this authorization covers records relating to communicable disease, Acquired Immunodeficiency Syndrome (“AIDS”) , Human Immunodeficiency Virus (“HIV”), behavioral, and/or mental health, alcohol and/or drug abuse treatment, genetic testing, of any such records exist.

I understand that at any time I have the right to revoke on this authorization to release medical records, except if the recipient has already taken action on this authorization. I understand that in order to revoke this authorization I must do so in writing, and send me revocation to the recipient. I also understand that the revocation only applies to records that have not been released in response to the authorization.

I understand that, once this information has been disclosed to a third party, that the information may not be protected by Federal Privacy Regulations and may be re-disclosed by the third party or entity that has received this information. I also understand that Ironwood Urology will not re-disclose my protected health information without my written consent.

I understand that this authorization does, and will explore one (1) year from the date of signing unless an earlier date is specified in writing. _____

Expiration date

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient (if not Patient)