

Pensacola Urology, P.A.

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AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Last Name (please print) _____ **First M.I.** _____ **Date of Birth** _____ **Social Security Number** _____

I hereby authorize _____ to disclose the following specific information from my health record from (date) _____ to (date) _____

Disclose to: (Name) _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Information to be disclosed (Please initial):

- Entire Health Record _____ Consultation Report _____
- Operative Report _____ Biopsy Report _____
- Progress Notes _____ History & Physical _____
- Lab Test (specify & initial) _____
- Other (specify & initial) _____

For the purpose of (circle all that apply): Continuity of care /consultation /personal/ insurance/ my request/ other (specify): _____

Disclosure to be: verbal _____ written _____

I understand if I do not authorize the release of my full health record, only a limited health record is provided per patient request. Provider will not require me to sign an authorization as a condition of my further treatment except where the treatment is for the purpose of research or solely for the purpose of creating a health record for disclosure to a third party and I refuse to authorize such disclosures.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. This authorization will expire 90 days from date of signature and I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. Pensacola Urology, P.A., and its employee's officers, and health care providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it may take 7 to 10 business days for this request to be processed. I further understand that I am entitled to a copy of the authorization.

Signature of Patient: _____ **Date** _____ **Phone** _____
Signature of Representative: _____

Witness: _____ **Date** _____

BAPTIST HOSPITAL The Medical Towers 1717 N. "E" St, Ste. 430 Pensacola, Florida 32501 Tel: 850.444.4707 Fax: 850.432.2532	SACRED HEART HOSPITAL DePaul Building 5147 N. 9 th Ave., Ste.103 Pensacola, Florida 32504 Tel: 850.494.1444 Fax: 850.494.0344	WEST FL MED CENTER 8333 N. Davis Hwy Ste. 7002 Pensacola, Florida 32514 Tel: 850.494.0224 Fax: 850.494.6679	GULF BREEZE HOSPITAL Professional Office Building 1118 Gulf Breeze Pkwy., Ste.204 Gulf Breeze, Florida 32561 Tel: 850.916.1799 Fax:850.429.9131
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