MISSISSIPPI
UROLOGY CLINIC, PLLC

Authorization for Use and Disclosure of Protected Health Information

1. PATIENT INFORMATION

Full legal name
PATIENT FULL NAME

MM/DD/YYYY
DATE OF BIRTH

2. INFORMATION TO BE RELEASED

I hereby authorize Mississippi Urology Clinic, PLLC to release / disclose the following. If you are requesting the complete record, you only need to select the first option.

- ☐ Complete Medical Record
- ☐ History and Physical
- ☐ Laboratory Tests
- ☐ Urodynamics Test Results
- ☐ Clinic Notes
- ☐ X-ray / Ultrasound / CT / PET Reports
- ☐ Inpatient Information
- ☐ Other: Specify records

3. PURPOSE OF RELEASE

- ☐ To transfer records to another provider
- ☐ For my personal use
- ☐ To provide an attorney with a copy of the record
- ☐ Other: Describe

4. RECIPIENT OF RECORDS (TO WHOM RELEASED)

Person or organization receiving the records
NAME OF PERSON OR ORGANIZATION

Street address
ADDRESS

City
CITY

State
STATE

ZIP
ZIP

5. DELIVERY METHOD

How should the records be delivered?

- ☐ Email
  By selecting Email, I authorize delivery to the address below and accept the risks of unencrypted email, which MS Urology cannot guarantee is secure.
- ☐ Fax
- ☐ Mail
- ☐ In-Person Pickup

Email address, fax number, or mailing address
DELIVERY CONTACT INFO — ENTER THE EMAIL, FAX NUMBER, OR MAILING ADDRESS FOR YOUR SELECTED METHOD (PICKUP NEEDS NONE)

6. TERMS OF AUTHORIZATION

Expiration: This authorization is effective for one year from the date of signing unless it is revoked or terminated earlier by the patient or the patient's representative. If no date is entered, this authorization expires one year from the date of signing. **Right to terminate or revoke:** I understand that I may revoke or terminate this authorization at any time by submitting a written request to Mississippi Urology Clinic, PLLC. A revocation will not apply to information that has already been used or disclosed in reliance on this authorization. **Potential for re-disclosure:** I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations (HIPAA).

7. SIGNATURE

I have read and understand this authorization and consent to the use and disclosure of my protected health information as described above.

Print full name

NAME OF PATIENT (PRINT)

SIGNATURE OF PATIENT

MM/DD/YYYY

DATE

Complete the lines below only if signing on behalf of the patient.

SIGNATURE OF PATIENT REPRESENTATIVE

MM/DD/YYYY

DATE

e.g., parent, legal guardian, power of attorney

RELATIONSHIP TO PATIENT

RETURN YOUR COMPLETED FORM TO

Email: ESCannon@cimplify.net

Fax: (601) 353-3654

In person: Mississippi Urology Clinic, 501 Marshall Street, Suite 301, Jackson, MS 39202