Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the above-named providers **Las Vegas Urology**, to release contents of medical records to my insurance company for purposes of billing and collecting as request. The undersigned acknowledges that without this authorization, **Las Vegas Urology**, may be unable to bill and collect from patients insurance company.
2. The information may be disclosed by employees or business associates of **Las Vegas Urology**.
3. The medical record information may also be disclosed to: ____________________ (insert name of the person or people to which the medical information may also be disclosed).
4. I acknowledge: that I have the right to revoke the authorization at any time, and that I understand that once the information is disclosed, it may no longer be protected by Federal Privacy law.

This authorization will remain in effect until terminated in writing by the undersigned patient.

You may revoke this authorization only in writing sent by certified mail to **Las Vegas Urology**, at the above address. The revocation will be in effective only upon receipt, except (1) to the extent that **Las Vegas Urology**, has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

Date: ____

Signed by: ____

Print Patient's Name:_______________________________________

If person signed is other than patient, state authority under which signature is made:

(The patient must be given a copy of the authorization)