HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: _____

Date of Birth: _____/_____/_____ E-mail Address: _____

I_____, hereby authorize and request _____ to release my health information (PHI) to:

North DFW Urology, LLP
1601 Lancaster Dr, Suite 170
Grapevine, TX 76051
817-481-7727 FAX 817-329-0077

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restriction (s) to releasing my PHI:

I understand that I am entitled to a copy of North DFW Urology, LLP's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website https://northdfwurology.us/ or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

_____

Signature of Patient Date: