PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

Dr Caleb Fleming, Lakeshore Urology, PLC
1445 Sheldon Road Suite 101
Grand Haven, Michigan 49417
Phone: 616.604.8363, Fax: 616.604.8364

to disclose certain protected health information (PHI) about me to:

Name:_____
Address:_____
Phone:_____ **Fax:**_____

This authorization permits the use and/or disclosure of the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of documents, level of detail to be released: Medical records for continuity of care. Office notes, operative notes, PSA other pertinent lab results, diagnostic test reports, biopsy results for the past two years.

This authorization will expire on _____, or one year from the signed date unless revoked by me in writing by sending a letter to Lakeshore Urology. Records released prior to any revocation will be considered valid. I understand that signing this authorization is not a condition of receiving treatment at Lakeshore Urology. I further understand that information disclosed pursuant to this authorization may be disclosed by the recipient and no longer protected by the federal privacy regulations.

I understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis and treatment for physical and/or emotional illness, including treatment for alcohol or chemical dependency for any admissions; also diagnosis, testing for and/or treatment for HIV infection, acquired immunodeficiency syndrome (AIDS) or acquired immunodeficiency syndrome related complex (ARC).

Signed by:_____ _____
Signature of Patient or Legal Guardian **Relationship to Patient**

Print Name:_____ **Date of Birth**_____

Date: _____