

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I authorize Keystone Urology Specialists to:**

Receive from:           OR            Disclose to:

Facility Name:

Facility Address:

Facility Phone:

Facility Fax:

Date information needed by:

Please check all that apply:

- Complete Medical Record    Lab/X-ray/Imaging reports    Pathology reports  
 Op/Hosp    Other: (Please specify):

The purpose for disclosing the above information:  
(Please check all that apply:)

- Continuation of care    Second Opinion    Change of Insurance    Legal  
 Relocating    Other: (please specify):

Re-disclosure: I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may be re-disclosed and may no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse/trtm or referrals for treatment; HIV information; and mental health services may NOT be re-disclosed per Pennsylvania state law and regulation and/or federal confidentiality rules.

If any of the below information is **applicable** and you **DO NOT** wish to have released, please check all that apply:

- HIV/AIDS related records    Mental health records    Drug/Alcohol abuse/trmt  
 Sexual abuse/assault

THIS AUTHORIZATION SHALL EXPIRE **90 DAYS** FROM SIGNATURE DATE, UNLESS SOONER REVOKED BY ME. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT PREVIOUSLY AUTHORIZED DISCLOSURE HAS BEEN ACTED UPON.

\_\_\_\_\_  
Signature of Patient/Guardian:

Date: \_\_\_\_\_

Other person authorized to sign authorization:

Relationship to patient:

***NOTE: if Power of Attorney - please attach a copy of POA papers to this authorization***

Mail or fax to: Keystone Urology Specialists  
2106 Harrisburg Pike; Suite 200; PO BOX 3200  
Lancaster, PA 17604  
Attn Medical Records  
Fax #: 717-393-2782