Authorization Form
The Urology Clinic & Georgia Lithotripsy and Laser Center

120 Trinity Place, Athens, GA 30607
Fax: 706) 353-3709

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Full Name: ____ **Date of Birth:** ___________________________
(Note: ***Form MUST be completed before signature is obtained)***
Patient's Mailing Address: ______________________________________ **Patient's Phone Number:** ______________

Patient's Physician:______ Dr. Allen _____ Dr. Ellison _____ Dr. Walton _____ Dr. Byrne
______ Dr. Young

This will authorize **The Urology Clinic, 120 Trinity Place, Athens, GA 30607** to use or disclose my protected health information to:
Name & Address of Practice/Person/organizations receiving the information:

____

____

For the following purpose(s)____

____

Specific description of information that may be used or disclosed:

____ Complete Medical record or _____ Other – Describe _________________________

____

Dates of care included: From: ____________________________ to ____

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form and that I may refuse to sign it. **Initials:** ________

b. I understand that I may see and obtain a copy the information described on this form, if I ask for it, and that I get a copy of this form after I sign it. **Initials:** __________

c. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation**. Initials:**______

d. I understand that information used or disclosed based on this authorization could be subject to re-disclosure by the party authorized to receive the records, and if so, may not be subject to federal or state law protecting this confidentiality. **Initials:** __________

(Over)

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Expiration Date: This authorization will expire on (list date or event)____ __

(If no date or event is stated, then expiration is SIX months from the date it was signed)

____

Signature of patient or patient's representative **Date**

Printed name of patient's representative: ____

Relationship to the patient/or authority to Act for the patient:

____

If the authorization has been given by the patient's personal representative, **The Urology Clinic** has verified the identity of (**Representative's Name**) by ____

Describe means of verification, e.g,, driver's license, and that in his/her capacity of the (**description of authority to act, e.g., husband, guardian, etc.**), he/she is authorized to act on behalf of the patient:________________________________

____

March 2003

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Please Read Below:

Patients will be charged for copies of medical records. The fees for are determined by the State of Georgia, under the office of the Governor and are updated annually. There is no charge for records sent to the patient's referring physician or physicians to whom we refer our patients.

The standardized fees are as follows:

Search, retrieval & other direct administrative costs		24.86
Certification fee		9.32
Copying costs	1 – 20 pages	0.93 per page
	21 – 100 pages	0.80 per page
	>100 pages	0.63 per page

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Signature of Patient or Patient's Representative **Date:**

March 2003