

BAY AREA RENAL STONE CENTER

**PATIENT AUTHORIZATION FOR THE RELEASE OF
OF MEDICAL INFORMATION**

Patient Name: _____ Date of Birth: _____

- 1. I authorize the use or disclosure of the above named individual's health information as described below.
- 2. The following individual or organization is authorized to make the disclosure:
Name: _____
Address: _____
City/State/Zip: _____
- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
_____ Complete medical record for _____ (dates of service)
_____ Specified Records _____ (dates of service)
_____ Specified Records _____ (dates of service)
- 4. I understand that the information in my health record may include information to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- 5. This information may be disclosed to and used by the following individual or organization:

For the purpose of: _____.

- 6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the above name individual or organization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
- 7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact BARSC's Privacy Officer at 727-521-3929.
- 8. My initials under each statement is my acknowledgement of the following statements:
 - a. I understand that Bay Area Renal Stone Center may not condition treatment on the completion of this authorization.
Initials: _____
 - b. I understand that I may revoke this authorization at any time by notifying the above name individual or organization in writing of my intent to revoke this authorization. If I do notify the above name individual or organization in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by the above name individual or organization taken before the revocation.
Initials: _____
 - c. Unless otherwise revoked, this authorization will expire: on the date, event, or condition specified; or one hundred and eighty (180) days from the date of this authorization.
Initials: _____

Signature of Patient or Legal Representative

Date

Printed Name of Legal Representative

If Signed by Legal Representative, Relationship to Patient

FOR OFFICE USE ONLY

Authorization witnessed by: _____

Representative's authority to act for the patient witnessed by: _____