SOUTHEASTERN UROLOGY ASSOCIATES
specializing in minimally invasive & robotic surgery

Authorization for Release of Information - Compound Release

Name of Patient _____Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Patient's Preferred Method of Contact: (please check one)
_____ Cell Phone _____ Work Phone _____ Home Phone _____ Text Message _____ Email _____

Description of Information to be released.	**Entity or Person whom patient approves to receive information.** Check each person/entity approved to receive information.
Results of Lab Tests/X-rays	☐ Spouse ☐ Voice Mail Message ☐ Text Msg ☐ Other (name: _____) ☐ E-mail Message
Medical Information/Breach Notification	☐ Spouse ☐ Voice Mail Message ☐ Text Msg ☐ Other (name: _____) ☐ E-mail Message
Appointment Reminders	☐ Spouse ☐ Voice Mail Message ☐ Text Msg ☐ Other (name: _____) ☐ E-mail Message
Financial/Insurance Information :	☐ Spouse ☐ Voice Mail Message ☐ Text Msg ☐ Other (name: _____) ☐ E-mail Message

☐ Cell Phone _____

☐ Home Phone _____

☐ Work Phone _____

☐ Text - please provide cell number*
_____

☐ Email communication - provide email address*
_____

* In order for email communication to occur, please accept the disclosure below:

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed or described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign the authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

***Description of Personal Representative's Authority (attach necessary documentation)**

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