WEST SHORE UROLOGY, P.L.C.
1301 MERCY DRIVE
MUSKEGON, MI 49444
231-739-9492 PHONE 231-739-8932 FAX

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____
_____to disclose certain protected health information (PHI) about me to: _____
Address: _____
_____

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 etc…) _____
_____
_____
_____.

This authorization will expire on _____, or one year from the date signed unless revoked by me in writing by sending a letter to West Shore Urology, P.L.C., Health Information Department. Records released prior to any revocation will be considered valid. I understand that signing this authorization is not a condition of receiving treatment at West Shore Urology, P.L.C. I further understand that information disclosed pursuant to this authorization may be re-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

_____ _____
Patient's Name — Patient's Date of Birth

_____ _____
Print Name of Legal Guardian — Date