

Urology Associates

OF DANBURY, P.C.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We will normally discuss your healthcare matters only with you. If you would like to authorize us to speak with others concerning your healthcare, Please write their full names and their relationship to you in the space provided. This includes spouses, parents, etc. if you do not wish anyone else to have access to this information please write "NONE".

*****This consent has NO expiration date unless indicated otherwise in the " Note" area**

_____ <i>Name of Person/Organization</i>	_____ <i>Relationship to Patient</i>	_____ <i>Notes</i>
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Signature

_____ <i>Signature of Patient</i>	_____ <i>Print Name of Patient</i>	_____ <i>Date</i>
_____ <i>Signature of Patient Representative</i>	_____ <i>Relationship to Patient</i>	

FILE: hipaa