



NORTHWOODS UROLOGY ASSOCIATES

HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please allow 7-14 business days for copying. There is a fee of \$25.00 for the first 25 pages, \$.50 cents per page after that, and any postage charges. The medical records cannot be released until this form is complete and signed by the patient or legal guardian.

You must complete this form thoroughly.

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Social Security#: _____ (Optional)

I hereby authorize Northwoods Urology Associates _____ to **Release** or _____ to **Obtain** my health information.

Name of Physician/ Medical Facility: _____

Address: _____

Phone #: _____ Fax #: _____

Information to be released/ requested: _____

Reason: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services, and treatment for alcohol and drug abuse.

_____ **Yes**, I consent to the release of this information. _____ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

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 individual or organization releasing information. I understand that the revocation will not apply to information already 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.

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 ensure treatment.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Northwoods Urology Associates liable for any misinterpretation in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of patient or Legal Representative

Date

Relationship to Patient(If Legal Representative)

Witness

135 Vision Park Blvd
The Woodlands, Texas 77384
281.404.3000

1501 River Pointe Dr.
Suite 160
Conroe, Texas 77304
936.441.6688

100 Medical Center Parkway
Suite 600
Huntsville, Texas 77340
936.435.9200

350 Kingwood Medical Drive
Suite 140
Kingwood, Texas 77339
281.359.1911

18059 Hwy 105 W.
Suite 115
Montgomery, Texas 77356
936.582.6454

24721 Tomball Parkway
Tomball, TX 77375
281.290.9800