UROLOGY CENTER
OF SOUTH FLORIDA,P.A.

MAIN OFFICE
10151 Enterprise Center Blvd., Suite 201
Boynton Beach, Florida 33437
Phone (561) 737-9191 • Fax (561) 737-2413

*Robert G. Gold, M.D.* • *William K. Skinner, M.D.* • *Joseph N. Biase, M.D.* • *Stuart M. Popowitz, M.D.*

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**PATIENT NAME**:_____ DOB:_____

I hereby authorize the following individual or organization to release my health information to the Urology Center of South Florida:

_____

_____

_____

**PLEASE SUBMIT THE FOLLOWING INFORMATION (FAX 561-737-2413):**

□□ Demographic information
□□ Medication list
□□ All PSAs
□□ Path report:_____

□□ Other:_____

_____

I understand that the health information authorized for disclosure may include information relating to sexually transmitted disease, AIDS, HIV, as well as behavorial, mental health services or treatment for alcohol or drug abuse.

I understand that I can revoke this authorization at any time, and I must do so in writing. The revocation will not apply to information that has already been released and will not apply to my insurance company. Unless otherwise revoked, this authorization will expire twelve months from this date. I understand that this authorization is voluntary and that I need not sign this form to assure treatment. I understand that I can inspect or copy the information to be used or disclosed, and that any disclosure of information carries with it the potential for unauthorized re-disclosure. If I have any questions about disclosure of health information, I can contact the Medical Record Department at 561-737-9191.

_____ _____
Signature of Patient or Representative Date

_____ _____
If Legal Representative, Relationship to Patient Witness