

OCALA UROLOGY SPECIALISTS, P.A.  
2850 S.E. THIRD COURT  
OCALA, FL 34471  
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**AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH  
INFORMATION**

Patient's Name \_\_\_\_\_  
Patient's Birth Date: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_

A. Person or Organization authorized to provide information

\_\_\_\_\_  
\_\_\_\_\_

B. Person or Organization authorized to receive the information

\_\_\_\_\_  
\_\_\_\_\_

C. Specific description of the information that may be used or disclosed (including dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Specific description of how the information will be used:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 1) I understand that this authorization will expire on \_\_\_\_\_.
- 2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the Privacy Officer, Susan R. Cline at 2850 S.E. 3<sup>rd</sup> Ct. Ocala, FL 34471 in writing.
- 3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits
- 4) I may inspect or copy any information used or disclosed under this agreement.
- 5) I understand that if the person or organization receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**