UROLOGY SPECIALISTS OF NEVADA

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - B

INFORMATION to Be Used or Disclosed
The information covered by this authorization includes:

□ Complete records	□ Biopsy results	□ CAT and MRI scans
□ X-rays	□ Urological related records	□ Nuclear Scans
□ Ultrasound	□ Pathological Slides	

□ All of the above

Note: Special dates of interest: _____

Persons Authorized to Use or Disclose Information (i.e.: those currently in possession of patient's info)
Information listed above will be used or disclosed by:

_____

Persons to Whom Information May be Disclosed
Information described above may be disclosed to:

Urology Specialists of Nevada
5701 W. Charleston Boulevard, Suite 201
Las Vegas, NV 89146
Phone: 702-877-0814 **Fax: 702-877-3238**

Expiration Date of Authorization
This authorization is effective through ____/____/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Urology Specialists of Nevada. You should contact the Privacy Official to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of Patient (Print or Type) Date of Birth Social Security Number

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient