



# Lubbock Urology Clinic, L.L.P.

## Authorization to Release of Medical Information

Patients Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Name: \_\_\_\_\_ SSN# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release medical information for the above named patient **TO / FROM:** (Circle One)

**Lubbock Urology Clinic, LLP**  
**6102 82<sup>nd</sup> Street #5**  
**Lubbock, Texas 79424**

**Purpose of Release:**

Continued treatment     Personal Use     Insurance     Legal action     Other: \_\_\_\_\_

**Documents Needed:**

<input type="checkbox"/> All Medical Information	<input type="checkbox"/> Hospitalization(s)
<input type="checkbox"/> All diagnostic test results	<input type="checkbox"/> Pathology reports(s)
<input type="checkbox"/> Radiology only	<input type="checkbox"/> Laboratory only
<input type="checkbox"/> Operative report(s)	<input type="checkbox"/> Hospital consult report(s)
<input type="checkbox"/> Progress note(s)	<input type="checkbox"/> Other (please specify)

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initiated below or otherwise required by law.

**May NOT include information related to (please check and initial):**

\_\_\_\_ HIV/AIDS                      \_\_\_\_ Mental Health                      \_\_\_\_ Drug and/or Alcohol Abuse

\_\_\_\_ I understand that I have the right to revoke this authorization at any time.

\_\_\_\_ I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to **Lubbock Urology Clinic, LLP. - 6102 82<sup>nd</sup> #5, Lubbock, Texas 79424**

\_\_\_\_ I understand that the revocation will not apply to information that has already been released in response to the original authorization.

\_\_\_\_ I understand that I may inspect or copy the information to be used or disclosed, as provided in DFR 164.524.

\_\_\_\_ 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 once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

\_\_\_\_ I understand this authorization will **expire 1 year** from the date of the patient/representative signature or upon the following date \_\_\_\_\_.

\_\_\_\_ I understand that I need not sign this in order to ensure health care at this facility.

\_\_\_\_ If I have questions about the disclosure of my health information, I can contact LUCs, privacy officer.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient (If Legal Representative)**

\_\_\_\_\_  
**Witness**

6102 82<sup>ND</sup> Street #5, Lubbock, Texas 79424  
Tel: (806) 771-0077 Fax: (806) 771-3175  
www.lubbockurology.com