WEST SHORE UROLOGY, P.L.C.
1301 MERCY DRIVE
MUSKEGON, MI 49444
231-739-9492 PHONE 231-739-8932 FAX

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize West Shore Urology, P.L.C., to use and/or disclose certain protected health information (PHI) about me to:

____.
Name of entity to receive this information

This authorization permits West Shore Urology, P.L.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.).

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This authorization will expire on ____________________.

I UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDE: DIAGNOSIS, PROGNOSIS, AND TREATMENT FOR PHYSICAL AND/OR EMOTIONAL ILLNESS, INCLUDING TREATMENT FOR ALCOHOL OR CHEMICAL DEPENDENCY FOR ANY ADMISSIONS; ALSO DIAGNOSIS, TESTING FOR AND/OR TREATMENT FOR HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX (ARC)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

West Shore Urology, P.L.C.
1301 Mercy Drive
Muskegon, MI 49444

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________
Patient's Name Patient's Date of Birth

______________________________ ______________________________
Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION