

WEST SHORE UROLOGY, P.L.C.
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**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize _____
to use and/or disclose certain protected health information (PHI) about me to:

West Shore Urology, P.L.C.

This authorization permits _____ 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.).

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)**

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