Columbia Urological Associate, P.A.
101 Berrywood Drive
Columbia, TN 38401

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Please check the box of the specific information to be used or disclosed:

❒ Test Results
❒ Labwork
❒ Office visit(s) Information
❒ Surgery information
❒ Medication information
❒ Other: _____

The following person(s) are authorized to make the request for the above information:

❒ Spouse: _____
❒ Parents: _____
❒ Children: Son: _____ Daughter: _____
❒ Leave on answering machine
❒ Other: _____

This authorization shall remain in effect from the date signed below until: _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research – related treatment, in which case you may refuse to provide that research-related treatment).

❒ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Signature: _____

Relationship to Patient
(if signed by personal representative of Patient): _____ Date: _____