The Florida Urology Center
Standard Authorization of use and disclosure of Protected Health Information

Information to be Used or Disclosed:_____
_____
_____**Purpose of the disclosure:**_____**Treatment**_____**Other**_____

Person authorized to use or disclose the above information:

Name of Dr/Facility **Telephone #**
1. _____
2._____
3._____

Person/Organization to Whom Information may be Disclosed:

- **The Florida Urology Center** **Phone:386-673-5100**
  300 Clyde Morris Blvd Ste C **Fax: 386-673-6014**
  Ormond Beach, Fl 32174

Expiration of Date Authorization
This authorization is effective through ____/___/___ or NO EXPIRATION (CIRCLE ONE) unless revoked or terminated by the patient or the patient's personal representative.
Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **The Florida Urology Center HIPPA Privacy Officer.**
Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature_____**DOB/SS#**_____

_____
Name of Patient (Print or Type) **Date**

_____
Signature of Patient Representative