Urology Group of New Jersey
UGNJ
375 Mt. Pleasant Avenue
Suite 250
West Orange, NJ 07052
973-323-1320 (phone) 973-323-1329 (fax)
www.ugnj.com

Authorization to Release Medical Information

1. **Authorization** This shall serve as authorization for the Practice to provide/release the information identified in section 2 below of Patient: _____ DOB: _____ to

   Name(s): _____
   Address: _____
   City/Town: _____ State: _____ Zip code: _____

   I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to obtain treatment from the Practice, except as provided in sections 4 and/or 5 below.

2. **Information to be Provided/Released** The Practice is authorized to release the Patient's entire medical record or, if the following section is completed, only such portion of the Patient's medical records as are specifically described in the following space:

   _____

   [identify records to be released, e.g. only lab results, only progress notes, only consultations]

   I understand that my records may contain information pertaining to the following:

   Drug and alcohol abuse and treatment
   HIV/AIDS/ARC
   Sexually transmitted diseases
   Tuberculosis
   Genetic testing and counseling
   Mental health information

   I understand that if I do not want any or some of the above information released, I may limit the Practice's authorization to release such information by crossing it out and initialing it. If there is other information that I specifically do **not** want released, I should identify it in the following space: _____. (If none, write "none"). I understand that any limitation on the Practice's ability to release certain information (such as information pertaining to a specific disease, condition or treatment), may result in the Practice's inability to release any or all of the record because of the way in which medical information is integrated throughout the record.

3. **Purpose/Use of Information Requested** The information requested will be used for my own purposes or if not, then it will be used for the following purpose: (if for your own purpose, write "my own purpose"):

   _____.

4. **Research Related Requests** If the purpose of this Authorization is for use and/or disclosure of health information for research conducted by or in which the Practice participates and I refuse to sign this Authorization, the Practice reserves the right to deny treatment associated with such research.

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5. **Certain Third Party Requests** If this Authorization is being requested by the Practice in order to release health information that would be created or obtained in connection with a third party's request for an evaluation or examination, such as a request by a life insurer, and that third party's agreement to pay for such evaluation/examination is conditioned on the release of such information, and I refuse to sign this authorization, I understand that the Practice may refuse such treatment unless and until services are paid in full.

6. **Marketing Purposes** If this Authorization is requested by the Practice so that it may use health information in connection with marketing activities, the Practice must indicate whether it is receiving compensation or anything of value for its disclosure of the health information. Unless otherwise indicated below, the Practice is not receiving anything of value for its disclosure of health information in connection with marketing activities.

   ☐ The Practice is receiving something of value for its disclosure of health information in connection with marketing activities.

7. **Patient's Right to a Copy of Authorization** If this Authorization is being provided at the request of the Practice so that it may use or disclose health information for its purpose, I understand that I am entitled to receive a copy of this Authorization from the Practice.

8. **Right to Revoke Authorization** I understand that I may revoke this Authorization at any time by notifying the Practice in writing at the address set forth at the top of this page. I understand that if the Practice has already released information or otherwise acted in reliance upon this Authorization, that any subsequent revocation will not affect the validity of the Practice's prior disclosure or other action. I also understand that if this Authorization was provided for purposes of obtaining insurance coverage, my revocation might give rise to the Insurer's right to contest a claim and/or to contest the validity of any insurance issued in reliance on the Authorization.

9. **Termination** If not revoked by me sooner, this Authorization will terminate on _____.
   [insert date or event or if no termination date is requested, write "none"]

10. **Right to Inspect Information** I understand that I have the right to inspect the information to be disclosed.

11. **Information Subject to Redisclosure** I understand that any information released pursuant to this authorization may be subject to further release by the recipient of this information and no longer protected by federal confidentiality laws.

_____ _____
Print Name **Signature**

_____ _____
Date **Relationship to Person Whose Records Are Sought**
(Such as Self, Guardian or Other Representative)