



Vanguard Urologic Institute

**AUTHORIZATION FOR USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Last Name: _____

Patient First Name: _____ M.I.: _____

Date of Birth: _____

I hereby authorize the Practice, _____, located in
_____, Phone: _____, Fax: _____
to disclose certain protected health information (PHI) about me to:

Vanguard Urologic Institute
(Includes Vanguard Urologic Associates & the Texas Prostate Center)
Memorial Hermann Medical Plaza
Attention: Medical Records Department or: _____
6400 Fannin Street, Suite 2300
Houston, Texas 77030
Medical Records: (713) 366-7802
Medical Records Fax: (713) 482-5807

Information to be release: **My complete medical record** – or – _____

HIV/AIDS. I DO _____ **DO NOT** _____ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

The information will be used or disclosed for the following purpose:

Transfer of my urologic care to the Vanguard Urologic Institute

If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire two years from the last date of service visit. A photocopy or electronic copy of this form will be considered valid as the original.

I do not have to sign this authorization in order to receive treatment from the Practice. I have the right to refuse to sign this authorization. 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 Officer at the Vanguard Urologic Institute.

Authorization granted by: Print Name: _____ Signature: _____

Date Granted: ___/___/_____ Relationship to Patient: ___ Self ___ Other - _____

Print Name of Patient or Legal Guardian: _____