Robert A. Bloom, M.D.
Diplomate, American Board of Urology

Authorization for Release of Protected Health Information

PATIENT NAME SSN:
DOB: PATIENT ID

I hereby authorize to release Protected Health Information (PHI) to:

Bay Urology Center
1937 Harrison Avenue
Panama City, FL 32405
850-818-0021 (Ph.)
850-818-0024 (Fax.)

Reason for Release:

SPECIFIC REPORTS REQUESTED (Check appropriate box):

☐ Medical Record Abstract (discharge summary, history and physical, operative, pathology, consults)

☐ History and Physical ☐ Discharge Summary ☐ Lab Results

☐ Operative Reports ☐ Consultations ☐ Imaging Reports

☐ Other:

- I understand that this information may include information relating to: acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes. Any release of substance information must be pursuant to 42 DFR. There are other special instructions which apply to the release of information regarding HIV, abuse reports, etc.
- I understand treatment, payment, enrollment, and eligibility for benefits are not conditional upon signed release of information authorization.
- I understand the recipient of the information can disclose it to others and the provider acting on this authorization cannot protect health information after disclosure to a third party.

Date:

Authorized Representative if Patient is Unable to Sign — Description of Authorized Representative's Authority — Date

Signature of Witness — Printed Name of Witness — Date:

This document has been electronically signed by <Approved By> on <Approved date time>.