ARIZONA FOCAL PROSTATE CENTER

HIPAA Privacy and Release of Information Authorization

Patient Name:
Patient ID:
Patient DOB:

I hereby authorize Arizona Focal Prostate Center and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) to other healthcare providers involved in my care and for treatment, for payment of services (through insurance companies or other entities) and in the course of healthcare operations.

I understand that any personal health information or other information released to the person or organization above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state laws or privacy laws.

I understand that I have the right to revoke this authorization by providing written notice to Arizona Focal Prostate Center, signed by me. However, such a revocation shall not affect any disclosures already made by the provider/organization in reliance of my prior consent. I also understand that I have the right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, my enrollment or payment for, or coverage of, services.

Arizona Focal Prostate Center provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy and grant the practice Medication History Authority.

If applicable, Legal Representatives please read and sign below:
By signing this form, I represent that I am the legal representative of this patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

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Patient's Printed Name **Date**

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Patient/Legal Representative's Signature