Authorization for Disclosure of Personal Health Information (PHI)

This office is dedicated to preserving patient privacy. Sometimes patients would like us to communicate with their spouse, family member, partner, or friend in order to help with communication and providing health care. You may revoke this at any time in writing.

The Person authorized to receive my personal health information:

Name (Printed):_____

Relationship:_____

Password or phrase to confirm: _____

_____

I hereby authorize the:

[ ] Discussion of my medical issues with the person listed above.

List any exceptions: _____

_____

[ ] Release a copy of my medical records to the person listed above (for a fee).

List any exceptions: _____

_____

Patient Name (Printed):_____

Signature: _____ Dated: _____

Practice (circle): Urology Center R Cyka, MD, Ltd.

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