The Urology Office of Dr. Michael S. Chune, Co (Inc)

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AUTHORIZATION TO RELEASE/TRANSFER MEDICAL RECORDS:

PATIENT INFORMATION.

Name _____

Address _____

SSN: _____

Date of Birth: _____

AUTHORIZATION FOR RELEASE: I, hereby authorize the office of Dr. Michael S Chune, Co to release, disclose, and deliver my office patient record to:

AUTHORIZED RECIPIENT:

_____

_____

_____

SPECIFIC AUTHORIZATION I specifically authorize release of summaries of my medical information relating to the above related patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment, (2) Mental health treatment; and (3) HIV, AIDS-related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, and any other information in the records whether generated by authorized provider or other entity.

I do not give permission for any other use or redisclosure of this information.

Patient _____Date _____

REDISCLOSURE. This released does not authorize redisclosure medical information beyond the limits of this consent. Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party, without further authorization. The following written statements should accompany certain disclosures:
This information has been disclosed to you from records protected by Federal confidentially rules (42 CFR Part 2 and 45 CFR Parts 106 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I specifically understand and agree that the redisclosure requirements set out above will apply to these records.
VALIDITY. I understand that this authorization will automatically expire 90 days from the date of my signature, and that I may revoke this authorization by sending a notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize release of information as indicated above

Dated and signed

Patient _____Date _____