GULF COAST UROLOGY
A Division of 21st Century Oncology, Inc.
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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Effective as of (5-05-03)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Persons/organizations authorized to use or disclose the information:
Persons/organizations authorized to use or receive the information:
Specific description of information that may be used/disclosed:
The information will be used/disclosed for the following purposes:
This authorization expires on or upon Date/Event:

The person/organization authorized to use/disclose the information will receive compensation for doing so.	☐ Yes ☐ No

- I understand that I may inspect or copy the information used or disclosed.
- I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that; a) action has been taken in reliance on this authorization; or b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
- Authorization will not limit Gulf Coast Urology's right to make use or disclosure that is required by law or permitted to avert serious threat to health or safety.
- All statements made pursuant to the authorization are binding.

Signature of patient or patient's representative	Date of Birth	Social Security Number
Printed name of patient or patient's representative	Relationship to patient or representative's authority to act for the patient	Today's Date

(A copy of this signed form will be provided to the patient)