

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
 (Name of individual) (Name of person or facility which has information)

release the following health information:

To:

South Bay Urology Medical Group Inc., a division of USSC

(Name of person/title or facility to receive health information)

20911 Earl St #140, Torrance, CA

(Street address, city, state, ZIP code)

(310) 542-0199

(Telephone number)

(310) 542-4652

(Fax number)

For the purpose of: Medical evaluation and treatment of above named patient.

This authorization is in effect until _____ (date or event) when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION
ON THIS FORM IS TRUE AND CORRECT.**

SIGNATURE

DATE

IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC