

**LONGVIEW UROLOGY, PLLC**

625 9<sup>th</sup> Avenue, Suite 120

Longview, WA 98632

360-425-3720 (phone)

360-425-0090 (fax)

I authorize Longview Urology, PLLC to use and disclose a copy of the specific health information described below regarding:

\_\_\_\_\_  
(PATIENT NAME)

Consisting of : \_\_\_\_\_  
(i.e. – medical records, x-rays, billing information)

**TO:** \_\_\_\_\_  
(Name and address of recipient)

For the purpose of: \_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and discloser of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- \_\_\_\_\_ HIV/AIDS information
- \_\_\_\_\_ Mental health information
- \_\_\_\_\_ Genetic testing information
- \_\_\_\_\_ Drug/alcohol diagnosis, treatment and referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

**PROVIDER INFORMATION:** You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive healthcare services is when the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that discloser.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or discloser already made with your permission cannot be undone.

To revoke this authorization, please send a written statement indicating you are revoking this authorization to:

Manager – Longview Urology 625 9<sup>th</sup> Avenue, Suite 120, Longview, WA 98632

**SIGNATURE:**

I have read this authorization and I understand it. Unless revoked, this authorization expires on \_\_\_\_\_.

**BY:** \_\_\_\_\_  
(patient or patient representative) Date

Description of personal representative's authority: \_\_\_\_\_

**PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION**

**Section A:** Patient to complete the following information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Telephone: \_\_\_\_\_

**REQUEST**

I hereby request that Longview Urology provide me with (check all boxes that apply):

Access to: My own copy of the requested information check below:

- My medical records regarding \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_
- My billing records
- Any other personally identifiable information used by Longview Urology to make medical decisions about me. Please describe:  
\_\_\_\_\_
- I am interested in access to or obtaining a copy of all requested information maintained by Longview Urology

I am interested in accessing or obtaining copy of the requested information relating to the following time period: \_\_\_\_\_ through \_\_\_\_\_

I would prefer to receive the requested information in the form of a summary prepared by Longview Urology at a cost to me of \_\_\_\_\_.

I wish to receive:

Photocopies

Electronic transmission  
(if available)

Other  
(if available)

**SIGNATURE:** \_\_\_\_\_

**PRINTED NAME OF LEGAL REPRESENTATIVE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_