Request to Send Protected Health Information to a Third Party

Patient's Name: ____ Date of Birth: _____________________

I request that **The Urology Group, P.C.** send a copy of my protected health information (PHI), described below, to the following individual:

☐ Mail Name: ____

Street
Address: ____

City
State, Zip: ____

☐ CD/disc ☐ Encrypted Email

Email Address:____

Please Print Clearly (If we cannot read your email address, we will not send your records.)

☐ Athena Fax
Fax number to receive records: ____

Please be advised that mailing your records on paper or by CD/disc will not be encrypted and may therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to mail paper copies or CD/disc of your protected health information to the address you have provided above.

☐ I acknowledge that I have been notified of the risk of the unencrypted means of transferring my records to a third party.

☐ Description of Protected Health Information to be disclosed:

☐ Healthcare information relating to the following treatment, condition, or dates of service:

____

____

☐ All healthcare information including test results (i.e. lab, radiology, pathology)

☐ Other: ____

____

Signature of Patient: ____ Date: ___________________

Name of Personal Representative (if applicable): ____

Signature of Personal Representative: ____________________________________ Date: ______________

Relationship to Patient: ____

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