Print

Swedish Urology Group, PC

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Authorization for Swedish Urology Group, P.C. to Use My Health Care Information

Name:_____ **Date of Birth:**_____
First Name *Last Name*

Previous Name: _____

I request and authorize _____
Provider's Name

_____
Street Address

_____
City, State Zip

_____
Phone Fax

to release healthcare information of the patient named above to Dr. Phillip H. Chapman, M.D. | M.D. or Swedish Urology Group, P.C., 1104 Madison Suite 1400, Seattle, WA 98104.

You may disclose the following healthcare information (check all that apply):

- ☐ All healthcare information in my medical record.
- ☐ Only healthcare information in my medical record relating to the treatment or condition listed:_____
  _____
- ☐ Only healthcare information in my medical record from_____ (date) to_____ (date).
- ☐ Other information (e.g. lab results, bills, etc.) Specify items and dates: _____
  _____

You may disclose healthcare information regarding testing, diagnosis and treatment for (check all that apply):

- ☐ HIV (AIDS Virus)
- ☐ Psychiatric disorders / mental health
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol use

Authorization ends:

- ☐ 90 days from the date signed
- ☐ on (date): _____
- ☐ when the following event occurs: _____
  (not longer than 90 days from date signed)

My Rights

- I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or employment).
- I understand that I may revoke this authorization by:
  - Filling out a revocation form available from Swedish Urology Group, P.C. or
  - Writing a letter of revocation to Swedish Urology Group, P.C.
- I understand that revoking this authorization would not affect any actions already taken by Swedish Urology Group, P.C. based on this authorization.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed mane if signed on behalf of the patient Relationship (parent, legal guardian, etc.)