



**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize **West Shore Urology, 1301 Mercy Drive, Muskegon, MI 49444** to disclose certain protected health information (PHI) about me to:

Dr. Caleb Fleming, Lakeshore Urology, PLC
1445 Sheldon Rd. Suite 102
Grand Haven, MI 49417
Phone: 616.604.8363 Fax: 616.604.8364

This authorization permits the use and/or disclosure of the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, types of documents, level of detail to be released:

Medical records for continuity of care. Office visit notes, operative notes, PSA other pertinent lab results, diagnostic test reports, biopsy results for the past two years.

This authorization will expire on _____, or one year from the signed date unless revoked by me in writing by sending a letter to West Shore Urology, PLC, Health Information Dept. Records released prior to any revocation will be considered valid. I understand that signing this authorization is not a condition of receiving treatment at West Shore Urology, PLC. I further understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

I understand that the specific type of information to be disclosed may, if applicable, include: Diagnosis, prognosis and treatment for physical and/or emotional illness, including treatment for alcohol or chemical dependency for any admissions; also diagnosis, testing for and/or treatment for HIV infection, acquired immunodeficiency syndrome (AIDS) or acquired immunodeficiency syndrome related complex (ARC).

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name: _____ Date of Birth _____

Patient Signature: _____ Date: _____

Date sent to West Shore: _____ [faxed] [mailed]