Simon Mirelman Urology, P.C.
Simon Mirelman, M.D., FACS

Confidentiality / Medical Records Release

Date: ______________________

I hereby authorize ***Simon Mirelman Urology, P.C.***, its agents, employees and contractors to release and disclose all or any parts of my medical records to the following family member, guardian, power of attorney, etc.:

Name: ____

Name: ____

Name: ____

And discuss any aspects of my medical condition and treatment with the above mentioned.

I hereby authorize the release and disclosure of any and all of my medical records to any other individual or entity, including, but not limited to, any referring physician, hospital, or other health care provider, which, in the opinion of the staff or physician of ***Simon Mirelman Urology, P.C***., may be of assistance in providing or continuing my medical care and treatment or for assisting in any reimbursement or benefits.

This authorization shall expire on ______________, or (2) two years from the date indicated above. I understand that I may revoke this authorization at any time, in writing, unless ***Simon Mirelman Urology, P.C.*** has relied on this authorization.

I understand that information disclosed pursuant to this release may be disclosed by the authorized recipient and no longer protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996.

___________________________________	______________________________
Patient Signature	***Witness Signature***

If the patient is a minor or unable to sign, then complete the following:

Patient is a minor___ or is unable to sign because_________________________________

___________________________________	______________________________
Signature & Relationship	***Witness Signature***