Viewmont
Urology Clinic, P.A.

1202 North Center Street Hickory, NC 28601 Phone: 828.322.4340

Authorization for Release of Individually Identifiable Health Information for Viewmont Urology Clinic Patients

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to Viewmont Urology Clinic.

Patient Name: _____ Chart # _____

Authorized persons to receive information: **OR** **( ) (check) DO NOT RELEASE MY INFORMATION**

(1) _____

(2) _____

(3) _____

I understand that before any information will be given to authorized persons listed above; they must confirm the patient's name, social security number, date of birth.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witnessed By Date

This is to acknowledge that I have been informed of the Notice of Privacy Practices of Viewmont Urology Clinic. I understand that this notice explains my rights to see and control the distribution of my personal health information. I understand that:

- The Notice of Privacy Practices is listed in the lobby, for me to read.
- It is posted on the Clinic's Web site (www.viewmonturology.com).
- I will be given a copy of these policies, upon my request.

Signed _____ Date _____

This notice will be placed in your records.