MIDATLANTIC UROLOGY ASSOCIATES, LLC.

PERMISSION TO RELEASE / OBTAIN MEDICAL INFORMATION

REQUIRED BY FEDERAL LAW

PATIENT (and/or GUARDIAN FOR DEPENDANT)

I, ____ hereby give permission to MidAtlantic Urology Associates, LLC., its employees, and sub-contractors to release current, past and future information about my medical condition, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six, that are required for us to care for you)

- My present and future health insurers.
- My referring or primary health care provider.
- Other health care providers caring for me.
- Health care providers/laboratories I am referred to.
- Health care facilities I am referred or admitted to.
- Authorized reviewers for regulatory compliance quality assurance and/or peer review.
- View / Obtain Medication History with past, present and future Pharmacies.
- My spouse or significant other ____.
- My parents ____.
- My employer (required for compensation cases) _____________________________.
- Others ____.

This permission will remain in effect until I revoke all or part of it in writing. I understand MidAtlantic Urology Associates, LLC., will make reasonable efforts to insure my privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed: _____________________________ Date: _____________ Witness: ___________________

HIPAA CARE REGULATIONS BROCHURE RECEIVED!

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SIGNATURE DATE

I, ________________________ hereby am notified that my Physician, Dr. ___________________ has ownership interest in the following entities: *Metropolitan Ambulatory Urologic Institute, LLC. (MAUI) /* _____________________/_____________________/_______________________, *and* ______________________________. I may now or in the near future receive additional treatment at one of these facilities. I hereby acknowledge that I have the right to request or may choose to obtain the referred services from a different health care entity.

Signed: _______________________ Name Printed: ______________________ Date: __________