

Sheldon J Freedman, M.D., F.A.C.S.
Diplomate American Board of Urology

Patient Authorization for Practice to Release Protected Health Information to Third Parties

If you would like other individuals such as family, friends, or other doctors to be able to contact our office and ask about your visits, please put their names in the space provided on this form. If you do not want anyone to be able to ask about your visits, please write none in the space provided.

By signing this authorization, I authorize Sheldon J. Freedman MD, Ltd. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Sheldon J. Freedman MD Ltd. to use or disclose any of my protected health information (PHI) to the following individuals:

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Sheldon J. Freedman, MD Ltd. has acted in reliance upon this authorization. My written revocation must be submitted to Sheldon J. Freedman, MD Ltd's privacy office at 9280 W Sunset Rd, Suite 200, Las Vegas, NV 89148.

Patient Signature

Date

Printed Name

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