John M Cannon, MD
Urology and Urologic Surgery
1770 Long Pond Road, Suite 101
Rochester, NY 14606
Telephone (585)244-8110
Fax (585)244-9435
www.cannonurology.com

Authorization for the Disclosure or Use of Protected Health Information

This form provides authorization to our practice to obtain or disclose your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used. You should carefully read the information on this form before signing it.

Patients Name _____ Date of Birth _____

__ I authorize John M Cannon, MD to **obtain** information from: *(Please send information to above address)*
__ I authorize John M Cannon, MD to **disclose** information to:

Name _____ phone # _____

Address _____ fax # _____

_____

Purpose for this request: __Health care __Insurance coverage __Personal __Other type of records requested

Type of records requested:
__Specific information _____
__Office notes: records from _____ to _____
__Medical records related to a specific illness or injury. Date(s) _____ Illness_____

This authorization is valid for:
__This request only.
__One year from the date of this authorization or _____ (date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
__This request and for medical records of any future treatment of the type described until: _____ (date)

I understand that:
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
I may cancel this authorization at any time by submitting a *written* request to above address. Such a cancellation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
My right to healthcare treatment is not conditioned on this authorization.
I have a right to inspect and to obtain a copy of any information disclosed from this authorization.

Signature of patient or representative _____ Date _____

Relationship to patient _____ (if requester is not the patient)