Male Release of Medical Records Authorization

Please fill out this form and send to your physician BEFORE your appointment. We request the dosing and recent labs prior to your next HRT appointment. In addition, for men over age 50, we request a current PROSTATE RECTAL EXAM REPORT and current PSA REPORT prior to your appointment.

To: _____ Date:_____

Your Doctor's Name

_____

Address

_____

City State Zip

Phone: (_ _ _) _ _ _ - _ _ _ _

Fax: (_ _ _) _ _ _ - _ _ _ _

I, _____, authorize_____

(Your Name) (Your Doctor's Name)

to disclose and release to Tutera Medical, Inc. and its Providers any individually identifiable health information related to me **from the last 2 years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- ☐ **Prostate Rectal Exam Report**
- ☐ **PSA Report**
- ☐ **Any Hormone Lab Results**
- ☐ **Dosage Sheet**

Are there any restrictions on PHI to be disclosed? Yes No

If yes, please explain:_____

This medical information may be used by Tutera Medical, Inc. and its Providers for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect for six months from the date on which it is signed, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

TUTERA MEDICAL, INC. DOES NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!

Send To: Tutera Medical Inc. and Providers
ATTN: Medical Records Department
8412 E. Shea Blvd Ste 101
Scottsdale, AZ 85260
Phone: (480)874-1515 FAX (480)991-8355

_____ _____

Print Name Date of Birth

_____ _____

Patient Signature Date