Urology Associates
12234 Williams Road, Cumberland, MD 21502
301-724-0132
301-759-5874 fax

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____/_____/_____

I hereby authorize the release of my Protected Health Information (PHI):

FROM:

Name: _____

Address: _____

_____

Phone: _____-_____-_____

Fax: _____-_____-_____

TO:

Name: _____

Address: _____

_____

Phone: _____-_____-_____

Fax: _____-_____-_____

Description of PHI to be released:

_____ Entire Medical Record _____ Dates requested: _____/_____/_____ to _____/_____/_____

_____ Other: _____

Include Information Relating To: _____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV/AIDS Related Information

I understand that this authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization (except to the extent that action was already taken as a result of this signed authorization) at any time by notifying the doctor releasing the information in writing. I understand that this authorization is intended as a release from all legal liability that may arise from the disclosure of the information requested.

_____ _____/_____/_____

Patient Signature (or patient's representative) Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient