COMPREHENSIVE UROLOGIC CARE, S.C.

AUTHORIZATION FOR RELEASE OF MEDICAL/PATHOLOGY RECORDS

Patient's Name_____

Address_____ City/State/Zip_____

Date of Birth ____/____/____ Last 4 digits of SSN _____ Phone ( ) _____

I, _____ hereby authorize to release information **TO CUC** or **FROM CUC**:
(PLEASE CIRCLE ONE)

Doctor/Agency/Self:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: _____ Fax: _____

Comprehensive Urologic Care, S.C.
22285 Pepper Rd. Bldg, 200 Suite 201
Lake Barrington, IL 60010
Phone: 847-382-5080 Fax: 847-852-1404

INFORMATION TO BE RELEASED

- ☐ Physician Office Notes
- ☐ Hospital/Surgery Reports
- ☐ Record Abstract (which includes all of the above)
- ☐ Radiology Reports
- ☐ Insurance Information
- ☐ Laboratory Reports
- ☐ Pathology Reports

☐ Pathology Slides to be shipped via Fed Ex at requester's expense after required prepayment of $50.00. Please contact the Medical Records Department at 847-382-5080 to make arrangements and provide additional information.

Concerning the care of the above patient from dates _____ to _____

These records are released for the purpose of (*Check all that apply*) ☐ **FMLA** ☐ **Disability**

☐ **Continuity of Care** ☐ **Attorney/client relationship** ☐ **Insurance** ☐ **At the request of the patient**

Allow 5-10 business days to honor requests for paper records/3-5 business days for pathology slides

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent those records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in six months unless expiration date is otherwise amended.

_____ _____
Signature: Patient or Legally Authorized Patient Representative Date of Signature

_____ _____ _____
Relationship to Patient Signature of Witness Date of Signature

Completed by: (Staff name) _____ ☐ For file only ☐ Action Needed