



COMPREHENSIVE UROLOGIC CARE

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Release of Information/Pathology Records

Patients Name _____ Date of Birth _____

Address _____

City, State, Zip _____ Telephone _____

I hereby authorize the release of my medical records

To be released to (Individual/Facility/Entity to be released to)

_____ Telephone _____ Fax _____

Address _____

Dates of Service to be released _____ to _____

INFORMATION TO BE RELEASED:

- Physician Office Notes
- Radiology Reports
- Laboratory Reports
- Pathology Reports
- Pathology Slides - shipped via Fed Ex at requester's expense after required \$50 prepayment. Please contact the Medical Records Dept. at 847-382-5080 to make arrangements and provide additional information.
- Hospital/Surgery Reports
- Radiology images on disk
- Insurance Information
- Record Abstract (which includes all of the above)

These records are released for the purpose of (Check all that apply)

- Continuity of Care
- Attorney
- Insurance
- FMLA/Disability*

*There is a \$25.00 processing fee for FMLA & Disability Paperwork

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. I also understand Comprehensive Urologic Care may not be responsible for the re-disclosure of protected health information or medical records by an outside entity and may no longer be protected by state and federal privacy laws and regulations. Comprehensive Urologic Care may not condition individual treatment, payment, enrollment in a healthcare plan or eligibility for benefits of a healthcare plan. I voluntarily sign this authorization.

Signature of Patient or a legal representative

Date of Signature

Witness Signature

Date of Signature

To be completed by office

Request Completed by: _____ Date: _____

For FMLA/Disability Paperwork: COMPLETE THE FOLLOWING

Payment Collected by: _____ (staff initials) Date: _____