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COMPREHENSIVE
UROLOGIC CARE

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Release of Information/Pathology Records

Patient Name ______________________________ **Date of Birth** ______________

Address ____

City, State, Zip ______________________________ **Telephone** ______________

I hereby authorize the release of my medical records

To be released TO CUC / FROM: (Individual/Facility/Entity to be released to)

______________________________ **Telephone** ____________ **Fax** ____________

Address ____

Dates of Service to be released ______________ to ______________

INFORMATION TO BE RELEASED:

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

☐**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.

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: __________