22285 N. Pepper Rd Ste 201Lake
Barrington IL 60010
p.847-382-5080 f. 847-852-1404
Medical Records
p.224-385-1126 f. 847-382-0923

COMPREHENSIVE
UROLOGIC CARE

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: (Individual/Facility/Entity to be released to) ____

Address____

Phone ______________________Fax______________________

To be released From: (Facility/Entity to be released from) ____

Address____

Phone ______________________Fax______________________

Dates information is to be released from: _____________________ to ____________________

INFORMATION TO BE RELEASED:

- ☐ **Physician Office Notes**
- ☐ **Radiology Reports**
- ☐ **Laboratory Reports**
- ☐ **Pathology Reports**
- ☐ **Hospital/Surgery Reports**
- ☐ **Radiology images on disk**
- ☐ **Insurance Information**
- ☐ **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**

To be completed by office

Request Completed by:______________ **Date:**_________

For FMLA/Disability Paperwork: COMPLETE THE FOLLOWING

Payment Collected by:________(staff initials) Date: ___________