

PALMETTO GREENVILLE UROLOGY

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MEDICAL RECORD RELEASE REQUEST

Patient Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Phone #: _____

The following person or facility is authorized to provide copies of the patient's identifiable health information:

RELEASE FROM: Name: _____

Address: _____

Phone: _____ Fax: _____

SEND TO: Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose for releasing the information:

Moving Away from Area Transfer of Care At Request of Patient For Patient Care

Describe the information that is to be released:

Office / Treatment Notes Lab Results CT Path Report Cytology Results

Other: _____

Indicate the dates of service that are to be released:

Entire medical records for services rendered at this office

Last office visit

Other (please specify): _____

I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.

I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. *Note: The revocation must be in writing and be delivered to the above address of the person/entity of whom was to release the information.*

I understand that unless earlier revoked, this authorization will expire 30 days after the date signed.

I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the medical records department.

I understand that I have the right to obtain a copy of this authorization.

PATIENT SIGNATURE: _____ DATE: _____

or Legal Representative of Patient: _____

(Attach Legal Representative Document)

Date: _____

WITNESS: _____

[OFFICE USE: DATE RECORDS SENT: _____ BY: _____]