Medical Records Request Form

This form is intended for use by patients requesting a copy of their medical records for their personal use or for delivery to another ***physician participating in their care***.

This authorization is HIPAA compliant pursuant to 45 CFR 164.508.

Patient Information

Last Name_____ First Name_____

Date of Birth_____ Daytime Phone #_____

Request Statement (Check one)

- All medical records
  - Partial medical record including: _____
- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____to_____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug use. I authorize the release or disclosure of this type of information.

This protected health information (PHI) is disclosed for the following purposes:_____

Authorize Statement (Check one)

You are authorized to release the above indicated records to the indicated representative above.

- I authorize MidLantic Urology to release my medical records directly to me.
- I authorize MidLantic Urology to release my medical records to the medical provider or clinic named below.
- I authorize _____to release my medical records to MidLantic Urology.

Provider/Patient Name_____

Address_____

City_____ State_____ Zip_____

Phone # _____Fax #_____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.(Please see the Notice of Privacy Practices)

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ Date_____

Patient Signature or Legally Authorized Representative with Title

Delivery Information (Check one)

- I prefer to pick up my records
- Please fax or mail my records to the medical provider indicated above.
- Please fax my records to MidLantic Urology at_____ .