MEDICAL RECORD RELEASE

South Shore Urology, Inc.
Fax Number 781-337-5095

Patient's Name: _____DOB: _____ Today's Date: _____

By signing this authorization, I hereby authorize SOUTH SHORE UROLOGY, Inc, 780 Main Street, S. Weymouth, MA 02190 to release health information, including copies of my medical records to the following person(s) at the address listed below for the purpose described:

Person(s): _____

Address to send records: _____

_____

INFORMATION TO BE RELEASED (Please check all that apply and specify dates.)

☐	Physician Notes	☐	Lab Results
☐	Radiology Report	☐	Operative Report
☐	Pathology Report	☐	Other (Specify) _____

Your initials are required here if you check any one of the next five boxes. INITIALS: _____

- ☐ HIV Results (Patient Authorization required for each release request.) Specify Date _____
- ☐ Alcohol and Drug Abuse Records (Federal Law prohibits any further disclosure of this information unless it is expressly permitted by 42CFR Part 2 or written consent is obtained from the concerned person.)
- ☐ Professional services of a licensed psychologist
- ☐ Domestic Violence Victims' Counseling/Sexual Assault Counseling
- ☐ Other: _____

PATIENT (or Legal Representative MUST read and initial the following statements.)

1. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.
   INITIALS: _____
2. I am requesting this authorization to expire on: _____
   (Leaving blank means there is NO EXPIRATION unless we receive a written request to cancel noting an expiration date.)
   INITIALS: _____

(Form must be completed before signing)

- The purpose of this request is: _____
- Please bring photo ID when picking up records.
- There is an initial $15.00 fee plus $0.50 / page for each of the first 100 pages, then $0.25 / page for each additional page for medical records. Fee is required at time of written request for medical records. We only accept cash or personal check for this request (no credit cards.)
- Pages to be copied _____ Amount $ _____

Patient Signature: _____

(Name of Legal Representative & Relationship: _____)

(Legal Representative's Signature: _____)

Date: _____