UROLOGY HEALTH SPECIALISTS
PROSTATE CANCER CENTER

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.

Request Statement (Check one)

- ☐ I request UHS Prostate Cancer Center to release my medical records directly to me.
- ☐ I authorize UHS Prostate Cancer Center to release my medical records to the medical provider or clinic named below.

Patient Signature _____ Date _____

Patient Information

Last Name _____ First Name _____

Date of Birth _____ Daytime Phone # _____

Delivery Information (Check one)

- ☐ I prefer to pick up my records
- ☐ Please fax or mail my records to the following medical provider

Provider Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Processing Instructions

Return this completed form to a UHS Prostate Cancer Center:

UHS Prostate Cancer Center
400 Davis Drive, Suite 200
Plymouth Meeting, PA 19462

Fax # 610-825-2162