



Exceptional Care. Personal Service.

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
- ☐ 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.

Patient Signature or Legally Authorized Representative with Title

Date

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 _____.