Medical Records Dept. Use
Date Rcvd: _____
Rcvd by: _____
Date Completed: _____
Completed by: _____
Patient Rcvd by PU Mail Email

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

I authorize _____
Physician's Name/Facility
Address: _____

Phone: _____ Fax: _____

to release my protected health information to: Physician/Facility Name/Self: _____

Address: _____

Phone: _____ Fax: _____

I authorize the release of the following information:

☐ Last 2 years ☐ Specific Treatment Dates: _____ to _____

☐ Laboratory/Radiology/Pathology Report Type: _____ Date: _____

☐ Other Specific Information: _____ Date _____

☐ Billing Records: Dates: _____ to _____

☐ HIV Results. Please initial authorizing our office to release this specific information _____

Purpose of request: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other: _____

I understand that I may revoke this authorization at any time by notifying Regional Urology in writing of my revocation. I understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation. I understand this authorization will expire one year from the signed date.

Patient Signature: _____ Date: _____

Patient Phone: Home: _____ Cell: _____

PATIENTS REQUESTING A COPY OF YOUR RECORDS

How would you like to receive your records? ☐Mail ☐Pick Up ☐ Secure Email: _____

If your records are over 25 pages, your records will be copied to a CD.

If you do not have computer access, please indicate you would like them printed. ☐ I want my records printed.

255 Bert Kouns ● Shreveport, LA 71106 ● (318) 683-0411 ● Fax (318) 683-0743