ADVANCEDUROLOGYASSOCIATES
MEDICAL RECORD REQUEST FORM

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
City/State/Zip: _____

I hereby authorize _____ to release the protected health information regarding the abovenamed person to:
Person/Institution/Other: _____
Address: _____ City/State/Zip: _____
Phone #: _____ Fax#: _____

The following types of information to be disclosed are as follows (select all that apply):
❑ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
❑ History and physical examination
❑ Consultation reports
❑ Progress notes
❑ Operative reports
❑ Abstract (documents summarizing history)
❑ Diagnostic reports (labs, pathology, x-rays, etc)
❑ X-ray films
❑ Other: _____

The following highly confidential items must be checked off to be included in the disclosure:
❑ HIV/AIDS related health information/records (410 ILCS 305/9)
❑ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
❑ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt.2)
❑ Genetic testing information/records (410 ILCS 513/30)

The above information for the following period of time shall be released from _____ to _____
(Date) *(Date)*

The purposes(s) of this authorization is (are): _____

Format of records desired: ❑ PRINTED PAPER ❑ ELECTRONIC CD-ROM

This authorization expires [date]: _____ . If not specified, this release will expire 1 year after the date of signature.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Advanced Urology Associates to use or disclose my health information in the manner described above.

_____ _____
Signature of patient or legal guardian, or authorized agent Date

If you are not the patient, specify your relationship to the patient: _____