REQUEST FOR MEDICAL RECORDS

Patient name: _____

Patient social security number: _____

Patient date of birth: _____

From: Physician/Medical facility _____

To: Physician/Medical facility: _____

Records should be delivered to (indicate office if in office access is requested). _____

_____

Information or records requested:

_____

_____

I understand that I have the right to access my medical records in accordance with the law and the policies of Urology Associates. I understand that Urology Associates may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that Urology Associates has the right to deny me access to my records in certain circumstances in accordance with the law. If Urology Associates denies me access to my medical information, I understand that it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of Urology Associates and may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature: Date: