



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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PLEASE PRINT AND SIGN YOUR NAME ONLY.

I, _____, ____ / ____ / ____ (Print Name)
First Middle Last DOB

Hereby authorize Urology Partners to: (check one please)

Release copies of Medical Records to:

Obtain my records from:

Name of Physician / Facility: _____

Address: _____
Street Suite City State Zip Code

Include the following Protected Health Information with my general Health Information:

Psychiatric / Mental Health

Sexually Transmitted Diseases

Alcohol and / or Drug Abuse

Hepatitis / HIV testing

Please be advised there may be a fee for copies.

Patient Signature: _____ Date: ____ / ____ / ____

NOTE: When releasing copies of your Medical Records

- **Turn-around-Time: Five (5 - 10) business days of receiving the written request.**
- **COPIES will be only of medical information from Urology Partners physicians.**
- **Fees - \$1.00 per page up to 25 pages and \$.25 per page thereafter.**