MediCopy

Central Ohio Urology

Authorization for the Release Of Medical Records

Which location or doctor are records coming from?

Location/Doctor's Name:

Tell us about the patient.

Name: DOB: SSN: XX-XX

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released?

Specific Categories

☐ All Records ☐ Office/Clinic Notes ☐ Hospital/ER Records ☐ Urgent Care Records

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Operative Reports ☐ Immunization Records

☐ Dates _____ to _____ ☐ Other _____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Why are we sending the records?

Purpose of Disclosure

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Transfer of Care/Continuation of Care

How would you like the records sent?

Delivery Method*

Email ☐ Fax ☐ Postage ☐

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) and/or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient or this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: