UACC
Urology Associates
Of Cape Cod, P.C.

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Medical Records Release Form

Patient Name: _____
Last First Middle

Patient Address: _____
Street City/Town State Zip Code

Patient Date of Birth: _____

I authorize the custodian of records of Urology Associates of Cape Cod, PC to disclose/release the following information (check all that apply):

*All Records_____ Ultrasound Disc*_____ Pathology Slides_____ Lab Records_____ Other_____*
There is a $40.00 charge for the shipping of ultrasound discs. Payable in advance to Urology Associates of Cape Cod, PC.

Check here if you are picking the records up at our Hyannis office: _____ Date needed by: _____

Check here if the records are to be sent to a facility or physician: _____ Date needed by: _____

Please send the records listed above to:

Hospital/Clinic or physician Name: _____

Address: _____
Street City/Town State Zip Code

Room/Floor/Suite Number: _____ *Phone:* _____ *Fax:* _____

Appointment Date (if applicable): _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient (or Representative) *Date*

_____ _____
Printed Name of Patient (or Representative) *Relationship to Patient*