UROLOGICAL MEDICAL GROUP OF NORTH ORANGE COUNTY
Adult and Pediatric Urology

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Name of Physician, Hospital or Facility

Address: _____
Address City State Zip Code

Phone: _____ Fax: _____

From: _____
Name of Patient

Re: **Request for Release of Medical Records**

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released **TO**:

Urological Medical Group of North Orange County
301 W. Bastanchury Rd. Suite 180
Fullerton, CA 92835
Fax (714) 870-4792

This authorization releases my medical records for the following designated purpose:

_____

This release is valid for 30 days after this date.

I understand that I am entitled to receive a copy of this release.

_____ _____
Signature of Patient or Legal Guardian Patient's Date of Birth

_____ _____
Print Patient's Name Date Signed

_____ _____
Print Name of Legal Guardian (relationship), if applicable Witness

REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

As a patient of *Urological Medical Group of North Orange County* (UMGONOC), you are entitled under federal law to access your personal Protected Health Information (PHI) maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the Privacy Officer. When received by the Privacy Officer, she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer, Rondi Muller, at 714-870-5970.

Patient Information:

Patient Name:_____ Date of Birth:_____

Phone Number:_____ Date of Access Request:_____

_____ I would like a copy of my PHI. I understand that UMGONOC may charge me a fee for the copies as set forth in the following fee schedule: $5 for the research and retrieval and .25 cents per page thereafter. I also understand that I will be required to pay the fee in full before I can obtain the copy.

_____ Pick up in Yorba Linda office

_____ Pick up in Fullerton office

_____ Mail to home address: _____

_____

_____I would like my PHI faxed to _____

at fax # _____ for the purpose of continued care, moving out of area, or changing providers. I understand that UMGONOC may charge me a fee for the copies as set forth in the following fee schedule: $15 flat fee. If records are mailed out of state, additional postage fees may apply.

I understand that UMGONOC is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site. UMGONOC may extend the deadline by thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

_____ _____

Patient/Representative Signature Date