Fax Cover Sheet

Authorization for Release of Medical Records

Urology Cancer Center
17607 Gold Plaza
Omaha, NE 68130
Phone: 402991-8468
Fax: 402-991-8469

Please fax with the attached medical records as requested below to Urology Cancer Center

To: Urology Cancer Center
Fax: 402-991-8469
Page Count: ________________

FROM:
Medical Facility: ________________
Physician: ________________
Phone: ________________
Date: ________________

Regarding Patient Name: ________________
Patient DOB: ________________

I, the undersigned, hereby authorize (physician & clinic) ________________

________________ To disclose the following personal health information for the purpose of scheduling a consultation visit by self-referral:

- All surgical pathology results from all biopsies and surgical procedures pertaining to my cancer;
- All laboratory results pertaining to my cancer;
- All prior treatment records including any systemic therapies, radiation treatment records, cryotherapy, clinical trials, or other pertinent therapies;
- All radiographic reports which are pertinent to my cancer;
- All physician notes pertinent to my cancer; including notes relating to the testing, diagnosis and/or treatment for HIV (AIDS virus; sexually transmitted diseases; mental health; drug and/or alcohol abuse.

PATIENT AUTHORIZATION:

Patient Name ________________

Patient Signature ________________ **Date:** ________________

This authorization shall expire one year from the date written above. I understand that I have the right to revoke this authorization at any time by providing my Health Care Provider with written notice of such revocation, sent by certified mail, fax, or hand delivery. I further understand that any revocation shall not be effective as to information already disclosed pursuant to this authorization.