# Urology Group of Western New England, P.C.

3640 Main Street, 1st Flr, Springfield, MA 01107
Phone (413) 785.5321 Fax (413) 731.7130

**REQUEST FOR PROTECTED HEALTH INFORMATION**

| | | | |
|---|---|---|---|
| Dr. | | | |
| | | | |
| Address | City | State | Zip Code |

Dr. _____ of The Urology Group of Western New England,
Requests the medical information on the patient named below.

| | | | |
|---|---|---|---|
| PATIENT NAME | | | |
| ADDRESS | CITY | ST. | ZIP CODE |
| PATIENT D.O.B. | | | |

I authorize the release of the following information for the period:

From_____ Through_____

| | |
|---|---|
| ▫ Office Notes | ▫ Operative reports |
| ▫ Laboratory reports | ▫ Urodynamic studies |
| ▫ Radiology reports | ▫ Consultations |
| ▫ Pathology reports | ▫ Other |

I understand that my Health Information may include general information related to my psychiatric health, drug/alcohol abuse, communicable diseases, abortion, or other information I may consider sensitive.
I understand that:
* This authorization pertains to information obtained on or before the date signed.
* This authorization is voluntary and I have the right to revoke this authorization at any time by presenting a written request to the Medical Records Department. Revocation will not apply to information that has already been released. I hereby authorize and request the release of my medical records TO *The Urology Group of Western New England.* The purpose of this request is for continuity of medical care. This authorization is valid for 90 days from the date of signature.

Please forward the requested information to:

☐ The Urology Group of Western New England
3640 Main St. Suite 103
Spfld. MA 01107

☐ The Urology Group of Western New England
10 Main St. Second Floor
Florence MA 01062

_____
Signature of Patient/Parent/Legal Representative DATE Relationship to Patient

_____
Witness to Signature DATE