U S M
UROLOGY SPECIALISTS
OF MILFORD, LLC
Jeffrey Steinberg, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Name of Patient_____
_
Address_____City_____State_____Zip_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____ Birthdate _____/_____/_____

I hereby authorize:

Name of Physician:_____

Practice:_____

Address_____City_____State_____Zip_____

Office Phone: _____-_____-_____ Office Fax: _____-_____-_____

to release the following medical records:

_____most recent office notes _____all pathology results _____ all radiology studies

_____ all operative notes _____ most recent lab test results

TO:

JEFFREY STEINBERG, M.D.

Urology Specialists of Milford, LLC
18 Asylum Street, Milford, MA 01757

PHONE: 508 473 6333 FAX: 508 634 0570

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

Signature of Patient:_____Date: _____-_____-_____