THE UROLOGY GROUP

www.urologygroupvirginia.com

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224-D Cornwall Street, NW ▪ Suite 400 ▪ Leesburg, VA 20176 ▪ 703-443-6733
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AUTHORIZATION FOR RELEASE OF PATHOLOGY SLIDES

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home) _____(Cell) _____

I hereby authorize The Urology Group to release medical records including slides concerning the above – named patient to:

Name authorized to receive records/slides: _____

Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Records: Please note that all slides are required by law to be retained at The Urology Group and are provided on a loan basis only. ***Slides must be returned*** to The Urology Group's medical records within 90 days of the loan.

I hereby release you, your physicians, and your employees from any and all liability the authorization request for release of medical information. This consent will expire ninety (90) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify The Urology Group in writing to that effect. I understand that my releases which were made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

I further acknowledge and understand that all patient slides are required by law to be retained at The Urology Group and ***must be returned*** to the medical record department no later than 90 days from the date they are loaned to me.

Patient Signature_____

Date: _____

Parent/Guardian/POA Signature_____

(Proof of designation as patient's guardian or attorney-in-fact must be attached to this authorization form)

Records prepared and transmitted by: _____

Date: _____

Please faxed signed form back to the Reston Office at 703-480-0280.