



UROLOGY

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**CONSENT FOR RELEASE OF MEDICAL RECORDS**

PLEASE RELEASE MEDICAL RECORDS FOR:

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ LAST 4 DIGITS OF SS# \_\_\_\_\_

TO:

NAME: \_\_\_\_\_  
(PHYSICIAN OR FACILITY)

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FAX: \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

***I authorize and request the disclosure of all protected information. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical records.***