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:_____
(PHYSCIAN OR FACILITY)

ADDRESS:_____

PHONE: _____

FAX: _____

_____ _____
Patient's Signature Date

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