ZUROLOGY

CONSENT FOR RELEASE OR OBTAIN MEDICAL RECORDS

Phone: 954-714-8200 • Fax: 954-840-2626 • Email: medicalrecords@zurology.com
5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076
ATTN: Medical Records Department

_____	_____	_____
NAME OF PATIENT	DATE OF BIRTH	SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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

[ ] I request my records ***go to*** the following Person/Provider:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

[ ] I request that you ***obtain*** my records from the following Provider:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Pleases send all records to
Fax: 954-840-2626
ATTN: Medical Records Department

[ ] I request my records be released ***to myself:***
(If records are to be released to you, please select this option)

[ ] Call patient to pick up records
Phone #: _____

[ ] Mail records to patient
Address: _____

_____

Please check **all that apply** to which medical records to be released/requested:

[ ] Notes [ ] Surgical Procedures/Imaging [ ] Lab Report(s) [ ] Ultrasound Reports/Imaging [ ] Complete Medical Record

For Dates of Service from: _____to: _____