UROLOGIC SURGEONS

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby authorize:
Patient Name (Please Print)

_____
Name of Physician, Hospital, or Agency

_____
Street Address

_____
City, State, Zip Code

to release medical records including visit summaries, laboratory and pathology results, and imaging reports to:

_____
Name of Physician, Hospital, or Agency

_____
Street Address

_____
City, State, Zip Code

The specific reports requested are:_____

Date of Birth: _____ Social Security #: _____

I understand this consent is revocable upon written notice to the physician, except to the extent that action has already been taken on this authorization. This is a lifetime authorization and is only irrevocable by a written notice from the patient. I release Urologic Surgeons from any and all costs, liability, or damages resulting directly or indirectly from the release of my medical records.

I acknowledge that I have read and fully understand this authorization as it applies to me.

_____ _____
Date of Authorization Patient Signature

_____ _____
Daytime Telephone Number Witness