Affiliated Urologist
Records Release Form

From: _____

Address: _____

I hereby authorize and request the release of copies of the following information:

Complete Medical Records X-Rays Other_____

Laboratory Records Procedures Report _____

INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE APART OF MY MEDICAL RECORDS.

To: Affiliated Urologist

Address: 1310 W Stewart Dr Ste 402 Orange County, California 92868

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability, which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth: _____

Social Security#_____ Phone # _____

Signature: _____ Date: _____

Circle One: Single Disclosure Continuing disclosure for 90 Days

Expiration Date: _____