



REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State, Zip

**Please forward my medical records to Consultants in Urology, 275 Orchard Street,
Westfield, NJ 07090 or fax to 908-789-8755.**

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES
ONLY: