



**REQUEST TO RELEASE MEDICAL RECORDS
TO ANOTHER PHYSICIAN/GROUP**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

City, State, Zip

By signing below I authorize the release of my medical records directly to:

Physician or Group Name: _____

Street

City, State, Zip

Phone Number _____ Fax Number _____

Signature of Patient or Legal Guardian _____ Date _____

Print Name of Patient or Legal Guardian _____

FOR INTERNAL PURPOSES
ONLY:

*Adult and Pediatric Urology • Sexual Dysfunction • Male Infertility • Urinary Incontinence • Urologic Oncology
Laparoscopic Surgery • Robotic Surgery • Radiation Oncology • Stone Disease Management • Pelvic Reconstruction*

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