CENTER FOR UROLOGY
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Dr. _____

Phone _____ Fax _____

I authorize you to furnish a copy of medical records of:

Patients Name (Please Print) _____

DOB _____ **SS#** _____

Covering the period from _____**, 200_ to** _____**200_**

I release you from all legal responsibility or liability that may arise from this authorization

This authorization includes consent to FAX records if necessary

____ **YES** ____ **NO**

Signed _____

Date _____

Witness _____