



**OUTSIDE PHYSICIAN TO UROLOGY ASSOCIATES
MEDICAL RECORDS RELEASE**

Last Name	First Name	MI	Date of Birth	Social Security #
Street Address		City	State	Zip

I authorize:

Name of Individual or Agency

Street

City State Zip

Telephone FAX

to release the following medical records and/or any requested information therefrom_____

TO:

- | | |
|--|---|
| <input type="checkbox"/> Craig W. Canfield, M.D. | <input type="checkbox"/> Jennifer Eckerman, P.A.-C. |
| <input type="checkbox"/> Michael deWit Clayton, M.D. | <input type="checkbox"/> Jessica Turner, P.A.-C. |
| <input type="checkbox"/> Paul W. Klosterman, M.D. | <input type="checkbox"/> Sara Woodruff, P.A.-C. |
| <input type="checkbox"/> Joseph R. Kuntze, M.D. | |

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 77 Casa Street, #202
San Luis Obispo, CA 93405
805-541-1111
FAX 805-544-0834 | <input type="checkbox"/> 525 E. Plaza Dr., #304
Santa Maria, CA 93454
805-349-7133
FAX 805-349-7137 | <input type="checkbox"/> 921 Oak Park Blvd., Ste. 202
Pismo Beach, CA 93449
805-473-7818
FAX 805-473-7820 | <input type="checkbox"/> 1310 Las Tablas Road, Ste. 201
Templeton, CA 93465
805-434-1408
FAX 805-434-1224 |
|--|--|--|--|

This information is for use by the recipient named above only. It cannot be given to any other individual or agency without the patient's consent.

Patient's Signature Date

Witness Signature Date

Signature Confirmed Expiration date
(no later than 6 years)