



# OUTSIDE PHYSICIAN TO UROLOGY ASSOCIATES MEDICAL RECORDS RELEASE

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LAST NAME FIRST NAME MI DATE OF BIRTH SOCIAL SECURITY #

\_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

**I AUTHORIZE:**

\_\_\_\_\_  
NAME OF INDIVIDUAL OR AGENCY

\_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

\_\_\_\_\_  
PHONE FAX

**TO RELEASE THE FOLLOWING MEDICAL RECORDS AND/OR ANY REQUESTED INFORMATION:**

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**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

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SIGNATURE CONFIRMED DATE