

UROLOGY ASSOCIATES, P.C.

MEDICAL RECORDS RELEASE

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS _____

HOME PHONE: _____ FAX: _____

RECORDS FROM: UROLOGY ASSOCIATES, P.C.
535 Plandome Road
Manhasset, New York 11030
Phone (516) 627-6188 Fax (516) 627-9397

RECORDS TO: PERSON TO RELEASE MEDICAL RECORDS TO:
I hereby authorize you to transfer or make available to:
(Print Physician's or Other Person's Name and Address and Fax Number)

Copies of the records and/or reports checked below relating to my/the above named patient's medical treatment:

___ Records and reports from: _____ to _____

Other (Specify) :

___ Radiographic Images (CD) ___ Slides ___ X-Rays

Urgent Request for Records () Date of upcoming appointment _____

X _____ DATED: _____
Patient Signature

X _____
Witness

X _____ *Verified* () *Date:* _____
Person Authorized for Pick-Up

Note: We require 7 to 10 business days to prepare your records for transfer.