

RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

UROLOGY ASSOCIATES, M.D., P.C.
535 PLANDOME ROAD
MANHASSET, N.Y. 11030

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS

AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____ #48, Rev. 3/02/06
(IF RELATIVE STATE RELATIONSHIP)

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