Cleveland Urologic Surgery, PA

Providing Complete Urologic Care for Men, Women and Children

MEDICAL RECORDS RELEASE

I, the undersigned, hereby authorize _____
to furnish from my medical records the information specified below,

- ❑ All Medical Records
- ❑ Imaging Reports
- ❑ Pathology Reports
- ❑ Operative Reports
- ❑ Laboratory Data
- ❑ History and Physical
- ❑ Pathologic Specimen
- ❑ Withhold the following _____
- ❑ Other _____

To: _____

Address: _____

City, State, Zip: _____

The records are requested for the following reason:

- ❑ Continued Medical Care
- ❑ Legal Purposes
- ❑ Insurance Purposes
- ❑ Personal Interest
- ❑ Other: _____

This authorization is effective immediately and will remain in effect until _____ (date).

I understand that I have a right to receive a copy of this authorization upon request and that I may revoke this authorization at any time by written notice.

Copy requested and received: Yes: _____ No: _____

_____	_____	_____
Print Patient's Name	Date	Date of Birth
_____	_____	
Patient's Signature (or legal guardian if minor)	Patient's Social Security No.	

Witnessed by: _____ Mailed/Faxed on: _____

FAX NUMBER – 704-484-0303