ASSOCIATED UROLOGISTS OF NORTH CAROLINA, PA

MEDICAL RECORDS RELEASE REQUEST

Regarding _____ _____

Print Name of Patient **Date of Birth**

By signing this authorization, I authorize:

PROVIDER OR CLINIC NAME _____

ADDRESS _____

CITY _____**STATE**_____**ZIP**_____

PHONE_____**FAX**_____

To release my records to:

PROVIDER Dr. _____, **Associated Urologists of North Carolina**

ADDRESS

_____

CITY _____**STATE North Carolina ZIP**_____

PHONE_____**FAX**_____

_____

PRINT NAME of Patient or Legal Guardian **SIGNATURE of Patient or Legal Guardian** **DATE**