SUMMIT UROLOGY

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*Treatment & Surgery*

# Medical Records Release

*Records will not be released unless the entire form is complete

Name of Patient:________________________ Date of Birth:________________

Address of Patient:______________________________________________

Name and address **FROM** whom the record is to be released:

__________________________________________________________

Name and address **TO** whom the record is to be released:

__________________________________________________________

**Purpose of the release:**

Transfer of medical care

Medical history to other physician or clinic

**Description of information to be released:**

All medical records

Medical record date (s) of service____________ to ___________

I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. Summit Urology does not take responsibility for any disclosure may by the individual above.

Signature of patient or legal representative:

Signature______________________ Witness______________________

Date__________________________ Date_________________________

**You may revoke or terminate this authorization by submitting your request in writing.

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