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RECORD RELEASE

DATE:_____

PATIENT NAME:_____

DATE OF BIRTH: ____/____/_____

ADDRESS:_____

I hearby authorize Middlesex Urology P.C. to release my medical records to _____

_____.

☐ Office Notes

☐ Imaging Studies (X-Ray, CT, MRI, PET, etc.)

☐ Laboratory Reports

☐ Surgical Reports

☐ Pathology/Biopsy Reports

☐ **Entire Medical Record**

From the time period of _____ to _____.

SIGNATURE:_____

WITNESS:_____