Scottsdale Center for Urology

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PATIENT CONSENT TO RELEASE MEDICAL RECORDS

Patient Information:

NAME: ______________________________ DOB: ______________

ADDRESS: ______________________________ PHONE: ______________

SIGNATURE: ______________________________ DATE: ______________

I hereby authorize and request you to (please check one or more):

Release records to the Scottsdale Center for Urology

Release records to the Physician(s) and/or Person(s) listed below

Discuss my care and account with the Physician(s) and/or Person(s) listed below

Name of Physician(s) and/or Person(s):

1. ______________________ Address: ______________________

____

Phone: ______________________

Fax: ______________________

2. ______________________ Address: ______________________

____

Phone: ______________________

Fax: ______________________

3. ______________________ Address: ______________________

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Phone: ______________________

Fax: ______________________

May 07