Authorization of Third Party to release medical records to AA Urology, PA and/or AA Urological Surgery Center, LLC.

Patient Name: _____

Date of Birth: _____

To (Outside Provider name): _____

Address: _____

Phone #: _____

Fax #: _____

This is to authorize the above named provider to furnish to:
AA Urology, PA or AA Urological Surgical Center LLC a copy of any and all medical reports, x-rays, bills, opinions and information in your possession concerning my diagnosis, treatment, prognosis and recommendations, including copies of any medical records. Please mail or fax records to:

AA Urology, PA
AA Urological Surgery Center, LLC
600 Ridgely Ave #222
Annapolis, MD 21401
Fax: (410) 266-0895
Tel: (410) 266-8049

A photocopy of this authorization shall be valid, and this authorization shall remain in effect until (specify date) _____ for a maximum of one (1) year from the date of its execution or until specifically revoked by me.

_____
Signature of Patient or Person of Interest

_____
Relationship to Patient (If request own records, write “self”)

_____
Witness