AA Urology

Care Compassion Community

Patient Name: ____ **Date of Birth:** _____________

Authorization for AA Urology PA/AA Urology Surgery Center LLC to release medical records to:

_______ Third Party _________ Patient (please check one)

Send Records to (name, address, phone, and fax number):

Provider Name/Facility: ____

Address: ____

Phone Number: ____

Fax Number: ____

This is to authorize AA Urology, PA or AA Urology Surgical Center LLC to furnish to the above-name individual 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 other medical records AA Urology, PA/AA Urology Surgery Center may have received from other health care providers.

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