

Sequoia Urology Center
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: _____

From:

Doctor and/or Facility: _____

Address: _____

Phone: _____

Fax: _____

To:

Doctor and/or Facility: _____

Address: _____

Phone: _____

Fax: _____

Released Information:

- Entire Chart
- Visit Notes
- Labs
- Imaging

Patient Signature: _____ Date _____

Note: There will be a \$25 charge for the preparation of medical records