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