Urology Specialists
of West Florida

MEDICAL RECORDS RELEASE

Name:_____Maiden Name:_____
Last First MI

Address:_____
Number City State Zip

Social Security #:_____

I authorize_____
(Doctor's Name)

_____
(Address) (City) (State) (Zip)

to furnish protected health information (PHI), including:

_____Office Notes _____Lab/Radiology _____Test Results

To: Urology Specialists of West Florida or _____
Address: _____ _____
of location _____ _____
_____ _____

I release and hold harmless _____MD and the providers' medical practice and employees, from all liability, including negligence that may arise from complying with this authorization. I understand that the medical record maintained may contain protected health information (PHI) from other health care professionals. I also understand that Urology Specialists of West Florida, LLP office policy requires prepayment of duplication costs incurred. As authorized by Florida law, fees for copying medical records are: $1.00/page for the first 25 pages, $.25 thereafter. (Chart review _____pages is $_____)

Signature:_____Date_____

Witness:_____Date_____

THIS AUTHORIZATION AND SIGNATURE WILL REMAIN VALID AS LONG AS I AM A PATIENT OF UROLOGY SPECIALISTS OF WEST FLORIDA LLP.