UROLOGY GROUP, P.A.
FOUR GODWIN AVENUE
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PEDIATRIC AND ADULT UROLOGY

**Patient Information:**

Last Name:________________________________First Name:________________________MI:_____

Birth Date:_______________________Social Security Number:__________________________

**Send Records to:**

Physician Name:__________________________________________________

Address:_________________________________________________________

City:__________________________________State:________________Zip Code:_______________

Phone Number:_________________________________Fax Number:__________________________

**Release Records From:**

Physician Name:__________________________________________________

Address: 4 Godwin Ave.

City: Midland Park State: NJ Zip Code: 07432

Phone Number: 201-444-7070 Fax Number: 201-444-7228

**Records Requested:**

**______ Complete Medical Records** **______ X-Rays**

**______ Lab Reports** **______ Other**

I authorize the release of my medical records to_______________________________________ from the physician and/or group who is named above. I release the above named physician and/or group from all legal responsibility or liability that may arise from the authorization.

**Signature of Patient** **Date**

**Signature of Witness** **Date**