

UROLOGICAL MEDICAL GROUP OF NORTH ORANGE COUNTY
Adult and Pediatric Urology

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(714) 870-5970

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Name of Physician, Hospital or Facility

Address: _____
Address City State Zip Code

Phone: _____ Fax: _____

From: _____
Name of Patient

Re: **Request for Release of Medical Records**

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

**Urological Medical Group of North Orange County
301 W. Bastanchury Rd. Suite 180
Fullerton, CA 92835**

This authorization releases my medical records for the following designated purpose:

This release is valid for 30 days after this date.

I understand that I am entitled to receive a copy of this release.

Signature of Patient or Legal Guardian Patient's Date of Birth

Print Patient's Name Date Signed

Print Name of Legal Guardian (relationship), if applicable Witness