



## AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I, authorize \_\_\_\_\_  
Contact

\_\_\_\_\_  
\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number

To release to Sisbarro Urological Specialists, Ltd (Provider) such medical records and related information as Provider requests, for the purpose of providing medical care and treatment concerning Patient \_\_\_\_\_.

Any restrictions that I wish to impose are listed below:

\_\_\_\_\_

I understand the Provider will not refuse to provide care to me if I refuse to sign this authorization.

This authorization is valid from one year from today's date unless I revoke this authorization.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient