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ADULT AND PEDIATRIC UROLOGY
UROLOGIC ONCOLOGY

INFERTILITY AND IMPOTENCE
REFERRALS 215-230-0600

# *MEDICAL RECORDS RELEASE REQUEST*

Patient
Name_____Date_____

Please send copies of my

- ☐ entire medical record
- ☐ most recent laboratory and/or x-ray results
- ☐ Other (please specify)_____

to the following:

Name_____
Address_____
Telephone Number_____
Fax Number_____

Patient Signature_____Date_____

Signature of parent or guardian (if patient is minor)_____

Please note: An administrative fee of $40.00 will be billed to the requesting insurance company. Medical record release request will be fulfilled within 5 business days.

For office Use Only:
Records sent on_____Employee Initial_____