Gulfshore UROLOGY
A Division of 21st Century Oncology, LLC

Release of Medical Records

Today's Date:__________________________

I, ____, hereby authorize the release of
(please print patient's name)
my medical records or copies of such from Gulfshore Urology and request that they are transferred to:

Doctor, Facility or Patient:____

Address:____

City: ____ State: ________ Zip: __________________

Phone:____ Fax: ____

Print Name of Patient:____ DOB: ___________________

Patient Signature: ____

Comments: ____

Date Picked Up:____________________________ Initials: _____________

Date Mailed: ______________________________ Initials: _____________

Date Faxed: ______________________________ Initials: _____________