

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: _____

BONITA SPRINGS

28930 Trails Edge Blvd.
Bonita Springs, FL 34134
(239) 333-3200
(239) 325-3037 Fax

COLLIER

8340 Collier Blvd., Ste. 400
Naples, FL 34114
(239) 333-3200
(239) 325-3037 Fax

NAPLES

955 10th Ave North
Naples, FL 34102
(239) 333-3200
(239) 325-3037 Fax

MARCO ISLAND

40 South Heathwood Dr.
Marco Island, FL 34145
(239) 333-3200
(239) 325-3037 Fax