Gulfshore UROLOGY
A Division of 21st Century Oncology, LLC

Request for Medical Records

Date: _____

To (Facility or Physician): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

I, _____, hereby authorize the release of my medical records or copies of such and request that they are transferred to:

Doctor: _____

Please check the appropriate LOCATION:

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

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

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

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

Print Name of Patient: _____ Date of Birth: _____

Patient Signature: _____

Comments: _____

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