

# Southwest Urology Associates

[www.southwesturologydallas.com](http://www.southwesturologydallas.com)

## Authorization for Release of Medical Records

Patient Information		
First Name _____	MI _____	Last Name _____
Date of Birth ____/____/____	Social Security No. _____-_____-_____	
Address _____		
City _____	State _____	Zip Code _____
Phone Number _____	Alternate / Cell Phone _____	

I authorize Southwest Urology Associates / Dr. \_\_\_\_\_ to **release my health information to:**

Name of Provider / Facility \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone Number \_\_\_\_\_ Office Fax Number \_\_\_\_\_

I authorize Southwest Urology Associates / Dr. \_\_\_\_\_ to **obtain information from:**

Name of Provider / Facility \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone Number \_\_\_\_\_ Office Fax Number \_\_\_\_\_

Please mail or fax records to:

<input type="checkbox"/> 1411 N. Beckley Ave., Suite 464 Dallas, Texas 75203 Phone 214.948.3101 Fax 214.941.7633	<input type="checkbox"/> 2705 Prince George Ave. Desoto, Texas 75115 Phone 972.780.0480 Fax 972.780.1453
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Records requested or to be released:

- Most recent physician notes
- Laboratory tests
- Operative reports
- X-Ray reports
- Other: \_\_\_\_\_
- All records

Authorization Valid for:

- This request only
- One year from date of release
- Other: \_\_\_\_\_  
Specific Date

\_\_\_\_\_  
Patient's Signature or Authorized Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of SUA employee handling request / release

\_\_\_\_\_  
Date received

\_\_\_\_\_  
Date records sent out