Rose Urology

REQUEST FOR RELEASE OF RECORDS

I, _____ request a copy of my complete

medical record from the office of:

Name and Address of Practitioner

To be sent to:

Rose Urology, LLC
Dr. Marc C. Rose, MD
PO BOX 644373
Vero Beach, FL. 32964-4373
hello@marcroseurology.com

_____ I give my permission to Fax my medical records to Rose Urology, LLC and Marc Rose, MD. I understand that my records will be sent via telephone communication.

_____ I give my permission to Mail a copy of my medical records to Rose Urology, LLC and Marc Rose, MD. I understand that my records will be sent via USPS or other mail service.

It is my understanding that by signing this authorization for release all my records, I am giving permission for Rose Urology, LLC and Marc Rose, MD to receive copies of any medical records related to the above-named person. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

Print Patient Name _____. Date of Birth _____

Signature of Patient_____Date _____