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## Release of Records

I, \_\_\_\_\_ hereby give Brandywine Urology Consultants authorization to release my medical records which include any and all office notes, laboratory studies, operative reports, pathology reports, radiology reports and any other special studies, etc. to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Physicians Name and date of appointment

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**\*\*\*Please allow up to 72 hours for all records requests to be processed and completed\*\*\***