# Urology Associate of Norwalk, PC

**Jonathan E. Bernie, MD ___**
**Stephen J. Batter, MD ___**
**Peter R. Dodds, MD ___**
**Scott R. Serels, MD ___**
**Dennis E. Shield, MD ___**
12 Elmcrest Terrace
Norwalk, CT 06850
Phone: (203) 853-4200 Fax: (203) 854-9285 or (203) 299-1938 (Dr. Serels office)

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Patient's Full Name:**_____

**DOB:**_____ **SS#:**_____ **Phone#:**_____

**Address:**_____

**PATIENT MUST PROVIDE COMPLETE INFORMATION IN ORDER TO PROCESS**
***Please note there is a $0.65 per page fee plus postage (if being mailed).***
***If we are forwarding your records directly to your Physician there is no fee.***

**Release records to: _____ Self or _____Other: (Name and Address)**

_____

**Fax:**_____ **Phone:**_____

**Please send a copy of my records as indicated for date(s) From:_____To:_____**

**___Office Visits ___Lab Reports ___X-Rays/Ultrasounds Rpts ___ALL**

**___Other:**_____

**Records shall be delivered by: ___Fax ___US Mail ___Other:**_____

**As required by the Health Insurance and Portability Act of 1996 and Connecticut Law, this practice may not use or disclose you health information without your authorization except as provided in our Notices and Practices.**

**Unless otherwise specified, I understand that this authorization allows the release of all information including information related to HIV status, substance abuse, and psychiatric illness and disabilities.**

**I, _____ hereby authorize release of my medical records as defined above. I accept the responsibility for any fees that may be associated with this request.**

**Patient's signature:**_____ **Date:**_____
**This consent is valid for 30 days from the date signed.**

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Office use only:

Acct#:_____ Payment collected:_____ Records sent on:_____