COLUMBIA UNIVERSITY
MEDICAL CENTER

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Records Release Authorization

I hereby request and authorize the release of a copy of my medical history and/or records concerning my illness and/or treatment, and any other medical information available.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Telephone: _____ Fax: _____

Date: _____ Date of Birth: _____

Signature: _____

Please check one or several boxes below:

- ☐ Columbia University, Department of Urology Physician
  Physician name: _____
- ☐ Other physician's office
  Physician name: _____
  Physician address: _____
  City:_____ State: _____ Zip Code:_____
- ☐ My home address (listed above)
- ☐ Alternate address
  Address: _____
  City: _____ State: _____ Zip: _____