UROLOGY ASSOCIATES OF RICHMOND, INC.

Jeffrey A. Rebman, M.D.

Linda B. Waterworth, ANP

Authorization for Release of Medical Information

Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Medical Record No.: __________

City: ______________________________ State: ________ Zip: ____________

Telephone Number: ______________________

I hereby authorize the release of my medical records to the name or entity listed below.

Name: ____

Address: ____

City: ______________________________ State: ________ Zip: ____________

This information is needed for the following reason: ___________________________

____

______________________________ ______________________________

Signature Date

____

Witness

1401 Johnston Willis Dr. · Richmond, Va. 23235 · Phone 804-320-1355 ·Fax 804-320-2786