Authorization to Release Medical Information

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SAN BERNARDINO UROLOGICAL ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO CHAPTER 782 (SB889), PART 2,6, SECTION 56 OF CIVIL CODE

The undersigned hereby authorizes: _____
Name of Doctor/Hospital

_____
Street Address City State Zip

To furnish the following medical information concerning me:

☐ All Medical Records ☐ Records from _____ to _____

The medical information authorized above is to be sent to:

San Bernardino Urological Assoc.
Franklin M. Chu, M.D., Daniel J. Lama, M.D., or Nimish Thaker, M.D.
489 E. 21st Street
San Bernardino, CA 92404

The undersigned understands that they are entitled to receive a true copy of this authorization on their request and that they may later modify or withdraw this authorization by written statement which is effective on the date of receipt of such notice by the above named provider of care.

The undersigned understands that the recipient of the information authorized to be released may not use the information for any purposes other than as stated above nor may they further release the information to anyone without a new authorization being completed.

Patients Name: _____
(Please print) Last First MI Any previous name

Date of Birth: _____ Spouse's Name: _____

_____ _____
Signature of Patient, parent, guardian or other legal representative Date

Witness Date

Franklin M. Chu, M.D., F.A.C.S.
Daniel J. Lama, M.D.

Diplomats American Board of Urology

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