CROSSROADS UROLOGY
West Central Ohio Urological Centers of Excellence

Request for Disclosure of Protected Health Information

Patient Name:_____ Date of Birth_____

Phone Number _____ Last 4 of SSN_____

Dates of Treatment _____

The purpose of this request is for:

☐ Continuity of Care

☐ At the request of the individual ☐ Selecting a new provider

The person identified above, do hereby authorize the release of my medical information, as indicated between the following parties:

FROM: PHYSICIAN RECORDS REQUESTED

NAME_____

ADDRESS:_____

_____

PHONE_____

LOCATION TO SEND RECORDS

Dr. Craig Nicholson
Crossroads Urology
2751 Fort Amanda Road
Lima, OH 45805
Phone: 567-529-9000
Fax: 419-948-4058

Medical Information Requested to be sent

- Complete Medical Record
- Radiology with printed report and all images on a Disk

_____

Signature of Patient or Legal Representative Date