

1221 Madison Street, Suite 1210 Seattle, Washington 98104

Telephone# (206) 292-6488 Fax#(206) 623-2436

**AUTHORIZATION TO RELEASE MEDICAL RECORDS
FROM SEATTLE UROLOGICAL ASSOCIATES**

I hereby authorize:

- James E. Gottesman, M.D., P.S. Wayne D. Weissman, M.D., P.S.
- James P. Gasparich, M.D., P.S. Joel D. Lilly, M.D., P.S.
- John S. Mullen, M.D., P.S.

to release my medical records to the physician/provider listed below:

Patient's Physician/Provider _____

Mailing Address _____

City, State, Zip _____

Telephone # _____ Fax# _____

Including the following medical information:

- Complete records All Urological related records
- X-rays CAT & MRI scans
- Ultrasound Nuclear scans
- Biopsy results Pathological slides
- All of the above

Special dates of interest _____ to _____

I understand that my express consent is required to release any healthcare information relating to test and diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health or drug and alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus) or sexually transmitted diseases, psychiatric disorders or mental health or drug and alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

Patient's Name

(Last) (First) (Middle Initial)

Social security# _____ Date of Birth _____

Mailing address _____

City, State, Zip _____

Signature _____ Date _____