UROLOGY ASSOCIATES OF SAN LUIS OBISPO
A Medical Group, Inc.

OUTSIDE PHYSICIAN TO UROLOGY ASSOCIATES
MEDICAL RECORDS RELEASE

Last Name _____ First Name _____ MI _____ Date of Birth _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

I authorize: _____
Name of Individual or Agency

_____
Street

_____
City State Zip

_____
Telephone FAX

to release the following medical records and/or any requested information therefrom_____

_____

TO:

- ☐ **Craig W. Canfield, M.D.**
- ☐ **Michael deWit Clayton, M.D.**
- ☐ **Christopher Johnson, M.D.**
- ☐ **Paul W. Klosterman, M.D.**
- ☐ **Joseph R. Kuntze, M.D.**
- ☐ **Hugh B. Perkin, M.D.**
- ☐ **Jennifer Eckerman, P.A.-C.**
- ☐ **Jessica Turner, P.A.-C.**
- ☐ **Sara Woodruff, P.A.-C.**

☐ 35 Casa Street, #370
San Luis Obispo, CA 93405
805-541-1111
FAX 805-544-0834

☐ 525 E. Plaza Dr., #304
Santa Maria, CA 93454
805-349-7133
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☐ 921 Oak Park Blvd., Ste. 202
Pismo Beach, CA 93449
805-473-7818
FAX 805-473-7820

☐ 1310 Las Tablas Road, Ste. 201
Templeton, CA 93465
805-434-1408
FAX 805-434-1224

This information is for use by the recipient named above only. It cannot be given to any other individual or agency without the patient's consent.

_____ _____
Patient's Signature Date

_____
Witness Signature Date

_____
Signature Confirmed Expiration date
(no later than 6 years)

Revised 12/05