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:_______________________

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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

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Signature of Patient or Legal Representative Date