Alan M. Freedman, M.D.
Board certified, American Board of Urology
Adult and Pediatric Urology

Medical Records Release Authorization

To: Doctor/Hospital _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

I hereby authorize and request you release records to:

Alan M. Freedman, M.D.
401 Old Newport Blvd, Suite 101
Newport Beach, CA 92663

( ) All urologic records **( ) CT/MRI scans** **( ) Nuclear scans**
( ) X-rays **( ) Ultrasound** **( ) Biopsy results**
( ) ER records **( ) Pathology results/slides**
( ) Other_____

Specific dates of above records requested _____ to _____

Patient Name _____ Date of Birth _____

Signature _____ Date _____

Relationship _____ Witness _____

401 Old Newport Blvd, Suite 101
Newport Beach, CA 92663
(949) 645-3434 Fax (949)645-0277