UROGYNECOLOGY ASSOCIATES OF PHILADEPHIA
Marc Toglia, M.D., FACOG
Urogynecology and Reconstructive Pelvic Surgery

MEDICAL RECORD RELEASE FORM

INSTRUCTIONS: Please complete this form in its entirety and forward it to the doctor or hospital that you wish to send your records to Dr. Toglia or his associates

By signing this authorization, I authorize Urogynecology Associates of Philadelphia to use and/or disclose protected health information (PHI) about myself.

PATIENT INFORMATION:
Patient Name: _____ Date of Birth; _____
Street Address: _____
City, State, Zip Code: _____

I HEREBY AUTHORIZE AND REQUEST MY HEALTH CARE RECORDS TO BE RELEASED TO:

Urogynecology Associates of Philadelphia
Marc R. Toglia, MD
Suite 3404, Outpatient Pavilion
1098 West Baltimore Pike
Media, PA 19063

Please forward the complete medical records in your possession concerning my treatment during the period from _____ TO _____ (insert dates).

Signature: _____ Date signed _____