Landmark Urology & Complementary Medicine, P.A.

Request for Medical Records

RE: ____ DOB: ___________________________
Print Name

By signing this authorization, I authorize:

____
Name of Doctor or Entity

____
Mailing Address

____
City, State, Zip Code

____
Telephone and Fax Numbers

To release my medical records to:

Mark W. McClure, MD, Daniel I. McRackan, MD, Cheri Elliott, ANP
Landmark Urology & Complementary Medicine, P.A.
3200 Blue Ridge Road, Suite 118
Raleigh, North Carolina 27612-8008
Phone #919-571-4399 Fax # 919-571-7627

Signed ____ Date ______________________
Signature of Patient or Legal Guardian

If this authorization is ***not*** signed by the patient please indicate the relationship to the patient of the person signing this authorization.

_________________________________ _____________________________________
Relationship to Patient | Date

__________________________________ ______________________________________
Signature | Print Name of Patient or Legal Guardian