James G. Knight MD
Board Certified Urologist

Request for Medical Records Instructions

The office telephone number - (619) 222-1114 - will no longer be answered but instead goes directly to voice mail that will be checked infrequently. It also receives faxes, primarily for written requests for the release of medical records, but the $35.00 processing fee must be received in advance.

Please carefully read and follow the instructions below:

If you were NOT a member of Sharp Community Medical Group and were last seen in my office after January 1, 2007:

The urologists at **Hillcrest Urological Medical Group** have assumed custody of your chart. As of December 23, 2009 your medical records were physically transferred to **Hillcrest Urological Medical Group** who became the official custodian of your medical record.

I am confident that you will continue to receive some of the best possible urological care available with these excellent doctors. Please contact them directly for further urological care or for any medical records needs:

Hillcrest Urological Medical Group
4060 Fourth Av. Ste 310
San Diego, CA 92103
Telephone: (619) 297-4707
Fax: (619) 297-2448
www.hillcresturology.com

HMO/ Sharp Community Medical Group Patients or Patients last seen in our office prior to January 1, 2007)

Before we can process your request for the release of your medical record, we must receive a $35.00 processing fee payable by check or money order, and a fully completed, signed 'Request for Release of Medical Records' (see the next page).

Please print, complete and sign a 'Request for Release of Medical Records', and mail the completed document along with the $35.00 processing fee to:

James G. Knight MD
PO Box 6580
Santa Fe, NM 87502-6580

James G. Knight MD
Board Certified Urologist

Request for Release of Medical Records

Send Fully Completed Requests and Administrative Fees* To:

James G. Knight MD
PO Box 6580
Santa Fe, NM 87502-6580
Or
Fax To: (619) 222-1114

***We must receive payment of the $35.00 administrative fee by check or money order before your request can be processed.**

Patient Identification Information:

Full Name: _____
Last Name *First Name* *Middle Initial*

Home Street Address: _____

Home City, State Zip Code: _____

Date of Birth: _____

Contact Phone Number: _____ Fax Number: _____
(###) ###-#### (###) ###-####

Request for Release of Medical Records:

I _____ request and authorize
Print Patient's Full Name Here

the release of any and all pertinent medical records to:

Doctor, Practice Name or Individual: _____

Street Address: _____

State, City Zip Code: _____

Area Code & Fax Number: _____

Area Code & Phone Number: _____

Patient Signature: _____ Date _____