

**James G. Knight MD**  
Board Certified Urologist

**Request for Medical Records Instructions**

My office telephone number - (619) 222-1114 - will no longer be answered but will instead go directly to voice mail that will be checked infrequently. It will also receive faxes primarily for use to receive requests for release of medical records.

**Non-HMO Patients (patients NOT members of Sharp Community Medical Group) and who were last seen on or after January 1, 2007:**

For your convenience I have arranged for the excellent urologists at **Hillcrest Urological Medical Group** to assume your urological care. These physicians are now the official custodians of your medical records. I am confident that you will continue to receive some of the best possible urological care available from 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](http://www.hillcresturology.com)

**For ALL Other Patients (HMO/ Sharp Community Medical Group Patients or Patients last seen in our office before January 1, 2007)**

A \$35.00 processing fee payable in advance by check or money order must be received along with a completed request for Release of Medical Records before we will transfer your chart to cover administrative overhead and mailing costs.

Please print, complete and sign a 'Request for Release of Medical Records' (see next page), and forward the completed document along with payment to:

James G. Knight MD  
PO Box 1149  
Las Vegas, NM 87701

Alternatively, you may fax the release to (619) 222-1114 and mail the \$35.00 payment to the above address, but your request will not be processed until the payment is received and has cleared your financial institution.

**James G. Knight MD**  
Board Certified Urologist

**Request for Release of Medical Records**

**Send this fully completed request and a check or money order for the \$35.00 administrative fee to:**

James G. Knight MD  
PO Box 1149  
Las Vegas New Mexico 87701  
Fax: (619) 222-1114\*  
\*Prepaid Administrative Fee Required

**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 or Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

State, City Zip Code: \_\_\_\_\_

Area Code & Fax Number: \_\_\_\_\_

Area Code & Phone Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_