AUTHORIZATION TO RELEASE MEDICAL RECORDS

From: _____

_____

To: _____

_____

I hereby authorize the above clinical professional staff to release all medical information contained in:

_____

My or Dependant's Name

_____ _____

Social Security Number Date of Birth

MAIL RECORDS TO:

Premier Urology Corp.
477 Cooper Rd. Ste. 220
Westerville, OH 43081
Ph: 614-818-0215
Fax: 614-818-0217

Doctors:
David H. Brown, M.D.
Jed W. Henry, MD
Adam J. Clemens, MD.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, and/or alcohol/drug abuse, and/or may include the results of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above.

_____ _____

Signature or Patient/Guardian Signature of Witness

_____

Date