

# 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.  
430 Altair Parkway, Ste. 200  
Westerville, OH 43082  
Ph: 614-818-0215  
Fax: 614-818-0217

Doctors:  
David H. Brown, M.D.  
Jed W. Henry, 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