

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
Daniel A. Cox, PA-C
Arlene F Hall, CNP

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