



**OUTSIDE PHYSICIAN TO UROLOGY ASSOCIATES MEDICAL RECORDS
RELEASE**

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS		CITY	STATE	ZIP

I AUTHORIZE :

NAME OF INDIVIDUAL OR AGENCY _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ FAX _____

TO RELEASE THE FOLLOWING MEDICAL RECORDS AND/OR ANY REQUESTED INFORMATION THEREFORM: _____

- TO:**
- | | |
|-------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Craig W. Canfield, M.D. | <input type="checkbox"/> Michael D. Clayton, M.D.,FACS |
| <input type="checkbox"/> Christopher W. Johnson, M.D., FACS | <input type="checkbox"/> Carol A. Karamitsos, M.D. |
| <input type="checkbox"/> Samuel B. Kieley, M.D. | <input type="checkbox"/> Paul W. Klosterman, M.D. |
| <input type="checkbox"/> Joseph R. Kuntze, M.D. | <input type="checkbox"/> Brett D. Lebed, M.D. |
| <input type="checkbox"/> Hugh B. Perkin, M.D. | <input type="checkbox"/> Jennifer Eckerman, PA-C, M.P.H. |
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THIS INFORMATION IS FOR USE BY THE RECIPIENT NAMED ABOVE ONLY. IT CANNOT BE GIVEN TO ANY OTHER INDIVIDUAL OR AGENCY WITHOUT THE PATIENT'S CONSENT.

_____ PATIENT'S SIGNATURE	_____ DATE
_____ WITNESS SIGNATURE	_____ DATE
_____ SIGNATURE CONFIRMED	_____ DATE