PREMIER UROLOGY ASSOCIATES, LLC-LAWRENCEVILLE

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Medical Records Release Form

Date_____
(This authorization will not expire)

Patient Name_____ Date of Birth _____
(Print)

To:

_____ _____

_____ _____

_____ _____

I hereby authorize the release of my medical records including diagnosis, treatment and/or examinations rendered to me by your office or institution for any and all conditions.

In agreeing to release my medical records, I am aware that anything pertaining to Psychiatric Disorders, AIDS/HIV, Drug and/or Alcohol abuse and the treatment of any of these disorders, if they are listed in my medical records, will also be released.

_____Date _____ _____
Signature of Patient or Legal Representative Legal Representative Relationship

_____
Witness's Signature

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