



**REQUEST TO COPY PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
Apartment #

\_\_\_\_\_  
City, State, Zip

**Please forward my medical records to Premier Urology Group, LLC, 608 Sherwood Parkway, Mountainside, NJ 07092 or fax to 908-789-8755.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**FOR INTERNAL PURPOSES  
ONLY:**

04/18/11/dp

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