PREMIER
UROLOGY GROUP, LLC
Consultants in Urology Division

MALCOLM SCHWARTZ, M.D.
BERNARD J. LEHRHOFF, M.D.
KENNETH S. RING, M.D.
MARK I. MILLER, M.D.
JOSHUA M. FISKE, M.D.
ANDREW J. BERNSTEIN, M.D.
ROBERT H. STACKPOLE, M.D.

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REQUEST TO RELEASE MEDICAL RECORDS TO ANOTHER PHYSICIAN/GROUP

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
City, State, Zip

By signing below I authorize the release of my medical records directly to:

Physician or Group Name: _____

_____
Street

_____
City, State, Zip

_____ _____
Phone Number Fax Number

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: