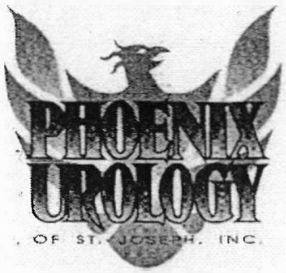
Michael E. Aberger M.D.
Mike Kozminski, M.D. *
Mark F. Lierz M.D. *
Bradley J. Moore M.D.



Diplomates
American Board of Urology *
Adult and Pediatric Urologists

REQUEST FOR MEDICAL RECORDS

Dr. _____

I, _____ hereby request that the following medical information be released. (Check all that apply)

___ Progress Notes ___ Pathology Reports

___Surgical Procedures ___ Other Diagnostic Tests_____

The information listed above will be released for the following purpose:

_____

The information described above may be released to:

_____

_____

_____
Signature of Patient/Representative of Patient Date

_____
Print Name of Patient/Representative Patient's Date of Birth

This authorization is effective through __/__/__ unless revoked or terminated earlier by the patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to Phoenix Urology. You should contact Medical Records to terminate this authorization.

_____
Witness Date

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