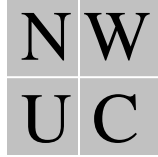


NORTHWEST UROLOGICAL CLINIC, P.C.

Physicians and Surgeons

General Urology:
Clifford O. Stranburg, M.D.
Thomas M. Pitre, M.D.
Michael T. Lavelle, M.D.
Stanley A. Myers, M.D.



Pediatric Urology:
David B. Lashley, M.D., F.A.A.P.
Daniel A. Hirselj, M.D.
Kelly M. Bartholomew, PA-C

Urologic Oncology:
Bruce A. Lowe, M.D.
Mandy M. Wiesman, PA-C

PERMISSION TO RELEASE MEDICAL RECORDS

Patient's Name _____

Date of Birth _____ Please Print Social Security No. _____

To _____
Medical Provider

Address _____

From _____
Medical Provider

Address _____

The following information may be released:

____ Laboratory Data ____ Medical Summary ____ Medication

____ Progress Notes ____ X-ray films ____ X-ray Reports

Other _____

Dates of service from _____ to _____

Permission expires 6 months from date signed _____
Specific date

Signature of patient or representative _____ relationship to patient

Date _____

1.) I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information:

Signature Date

2.) I recognize that the information disclosed may contain information regarding SEXUALLY TRANSMITTED DISEASES OR HIV/AIDS TESTING. I specifically consent to disclosure of such information:

Signature Date

3.) I do _____ do not _____ specifically consent to transmission of my medical records via a facsimile (FAX) machine:

Signature Date

This permission may be revoked unless action has already been taken