John J. Bauer, M.D., F.A.C.S.

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MEDICAL RECORD/X-RAY RELEASE AUTHORIZATION

DOCTOR / HOSPITAL: **John J. Bauer, MD, FACS**

ADDRESS: **G-1121 West Hill Road**

CITY, STATE, ZIP: **Flint, Michigan 48507**

I hereby authorize and request you to release to John J. Bauer, MD, FACS at the address listed above, the following medical information.

[ ] Complete medical records
[ ] X-rays
[ ] Ultrasounds
[ ] Biopsy results
[ ] Complete lab work
[ ] Urological related records
[ ] CT & MRI scans
[ ] Nuclear Scans
[ ] Pathological slides
[ ] All of the above

Note: We are especially interested in any studies or records between the period of __________________________ to ____________________________.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health, drug or alcohol use. If I have been tested, diagnosed or treated for the above stated conditions, you are authorized to release all health care information pertaining to such testing, diagnosis, and/or treatment.

Patient Name: ____
Social Security Number: _________________________ **Date of Birth:** _______________
Address: ____
City, State, Zip: ____
Signature: __________________________________ **Date:** ___________________________
Witness: ___________________________________ **Date:** ___________________________