John J. Bauer, M.D., F.A.C.S.
www.flinturology.com
Urology Services, Inc.
G-1121 West Hill Rd.
Flint, Michigan 48507
Tel: 810.232.8888
Fax: 810.232.9190
Email: jbauer@flinturology.com

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:** ________________________