RECORDS RELEASE AUTHORIZATION

TO:_____
Physician or Hospital

_____
Address

I hereby request and authorize you to release to:

Urology Associates of Elkhart, Inc.

Jerald A. Hochstetler, M.D.
Anish H. Nayee, M.D.
Peter C. Fretz, M.D.
Timothy J. Roth, M.D.

105 N. Nappanee Street
Elkhart, IN 46514

☐ the complete history records in your possession concerning my medical care

☐ only medical records concerning my medical care and treatment for the time period of _____ to _____

☐ only medical records concerning my medical care and treatment for the diagnosis of _____

Mental illness, substance abuse and/or HIV information ☐ **SHOULD** ☐ **SHOULD NOT be included**.

Patient Name:_____DOB:_____

Address:_____

I understand this authorization may be revoked by written request.

Date Requested:_____

Patient (or Guardian) Signature:_____

Urology Associates Account Number:_____

Witness:_____