RUSSEL H. WILLIAMS M.D.

Board Certified in Urology

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Spouse Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Russel H. Williams, MD to receive/release (circle one) healthcare information of the patient named above from/to (circle one):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

You may submit my medical records by:

☐ Fax to the following number:_____

☐ Mail to the following address: _____

☐ will be picked up by the following individual : _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Witness: _____ Date Signed : _____