Authorization for Release of Information

To: ______________________________________

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I hereby authorize you to release the requested information regarding the

patient: ____

From your records to:

Michael P. Verni, M.D.
Urology Center
653 N. Town Center Drive, Suite 302
Las Vegas, NV 89144-0517
(702) 212-3428 Fax: (702) 212-3452

The patient was treated from __________________________ to __________________________

Please include the following:

_____**ENTIRE RECORD**

_____All Operative Reports
_____All Laboratory Reports
_____Ultrasound Reports
_____Pathology Reports
_____Progress Notes
_____All Radiology Reports
_____Discharge Summary(ies)
_____History & Physical(s)

_____OTHER____
____
____

Dated this ____________day of ________________________, 20________

____ ________________________
Patient's signature Date of Birth

___________________________________ ______________________________________
Social Security Number Witness

05/18/2017