

CLINIC OF UROLOGY, S.C.  
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Phone: (414) 672-6006

RE – RELEASE OF MEDICAL INFORMATION/ DOCTOR DIALOGUE WITH  
FAMILY MEMBERS:

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
(Please print name)

I GIVE PERMISSION

TO: \_\_\_\_\_  
NAME RELATIONSHIP

TO SPEAK TO MY PHYSICIAN AND/OR HIS STAFF REGARDING MY  
CONDITION AND CARE.

THIS LETTER SHALL STAY IN MY MEDICAL FILE PERMANENTLY OR UNTIL  
SUCH TIME AS I REVOKE THIS LETTER.

SIGNED: \_\_\_\_\_  
PATIENT NAME