Carey B. Ransone, M.D.
Board Certified Urologist

Authorization to Release Medical Information

Date: _____

I _____, hereby authorize Progressive Urology, PC to release information regarding my medical care to the following: (Please choose as many as apply),

Spouse: _____ Parent: _____

Son: _____ Daughter: _____

P.O.A.: _____ Other Relative: _____

Friend: _____

This release is in effect until written termination is submitted by me.

_____ _____
Patient Signature Date

_____
Date of Birth