Ross Cohn, MD *Angie Ogle, APN-C*

Hixson Urology
2051 Hamill Road, Suite 201
Hixson, Tennessee 37343
Phone: 423-877-2844 Fax: 423-877-1959

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____

Patient Address: _____

City:_____ St: _____Zip:_____

Date of Birth: _____Social Security #:_____

Release From: Hixson Urology
2051 Hamill Road, Suite 201
Hixson, TN 37343 Phone 423-877-2844 Fax 423-877-1959

TO: _____

Address:_____

City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____

MAIL RECORDS_____ FAX RECORDS _____

Check any or all information that you want sent.

( ) History & Physical ( ) Progress notes ( ) EKG reports
( ) Consultations ( ) Laboratory reports ( ) Other-Specify:_____
( ) Operative reports ( ) Pathology reports _____
( ) Discharge summary ( ) X-Ray reports _____

I give my consent for this medical information to be released and hereby release Dr. Cohn or Angie Ogle NP and Hixson Urology from all legal liability that may arise from the release of the information requested. I understand that this release is good for 60 days from the signed date but may be revoked by my written request at an earlier date.

Signed:_____Date:_____
Patient or Authorized Representative
Relationship if other than patient:_____

Witness:_____Date:_____