



## Request for Release of Medical Records

Date \_\_\_\_\_

To: \_\_\_\_\_

I authorize you to release all of my medical records to:

**Cleveland Urologic Surgery, P.A.**  
**Fax # 704-484-0303**

I understand that this will include all medical records, including treatments, lab tests, and x-rays.

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Robert P. Gossett, M.D.

Shem K. Blackley, III, M.D.

Michael E. Brame, M.D.

1001 North Washington Street    Shelby, NC 28150    704-482-2011