



JOEL R. LOCKE MD, FACS

STARLING C. EVINS MD, FACS

RELEASE OF BILLING & MEDICAL INFORMATION

(1) I, _____ authorize Starling C. Evins, M.D., Joel R. Locke, M.D., or the office staff at Franklin Urological Associates to release any or all information regarding my medical treatment to the person(s) listed below. I understand that by signing this release that the designated person(s) will be able to speak with any staff member at Franklin Urological Associates. I also understand that if there is a change in my designated person(s), it is my responsibility to notify Franklin Urological Associates of this change.

Please list designated person(s) below, if there is no designated person(s) just write in "PATIENT ONLY"

Name: _____ Relation: _____
Address: _____
Phone: _____

Name: _____ Relation: _____
Address: _____
Phone: _____

(2) Please list the telephone number(s) that staff members at Franklin Urological Associates can contact you at during our business hours of 8:00am-5:00pm Monday –Friday.
Phone # _____ Phone# _____

(3) Do you have an answering machine or voice mail on the above listed phone numbers?
YES _____ or NO _____
IF YES, can staff members at Franklin Urological Associates leave a message on them?
YES _____ or NO _____

Patient Signature: _____

Date: _____