

PREMIER UROLOGY ASSOCIATES, LLC-LAWRENCEVILLE  
GARY S. KARLIN, M.D., FACS  
RUSSELL M. FREID, M.D., FACS  
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Date: \_\_\_\_\_

Patient: \_\_\_\_\_

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

I authorize Lawrenceville Urology PA to release my original ultrasound/

films/pathology slides to me to take to \_\_\_\_\_

\_\_\_\_\_.

I understand that these are original films/slides and must be returned to this office as they cannot be duplicated. I will be responsible for making sure that these films are returned to Lawrenceville Urology PA.

Signature of Patient: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness to Signature: \_\_\_\_\_