BENRUS SURGICAL
AT BARNES-JEWISH ST. PETERS

TO WHOM IT MAY CONCERN:

I, the undersigned, do hereby authorize the release of my medical records and any other information relative to my treatment of ________________________________

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Records to be faxed/mailed to: Benrus Surgical @ BJSPH
70 Jungermann Circle, suite 405

St. Peters, MO. 63376

PH) 636-916-7100 Fax) 636-916-7110

Patient Name: ____

Date of Birth: ________________________Patient Phone #:____________________

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Signature of Patient (GUARDIAN SIGNATURE if PATIENT is a MINOR)