AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I____, hereby request and authorize:

Dr.____

to release my medical records to:

David L. Gottesman, M.D., F.A.C.G.
Don E. Brinberg, M.D.
Peter Yang, M.D.
Miriam L. Vishny, M.D.
Steven M. Schwartz, M.D.
Jason M. Wolf, M.D.
Gregory S. Powell, M.D.
Michael J. Pollack, M.D.

Lake West Medical Building
36100 Euclid Avenue #440
Willoughby, Ohio 44094
Phone (440)942-7909
Fax (440)942-7846

_____ All medical information in his/her possession

______Specific information as follows:

____

FROM THE RECORDS OF:

____________________________________ ___________________________

(Please print patient name) (Date of birth)

Unless expressly revoked sooner, this authorization will be honored for a period of sixty(60)days from the date of signature. Receipients will at no time redisclose this information. PLEASE DO NOT SEND ORIGINAL RECORDS.
I understand that my records may contain alcohol and/or drug abuse information, mental health information, HIV test results, or a diagnosis of AIDS or AIDS related condition. I expressly consent to the release of such information contained in the medical records designated above.

SIGNATURE:____ DATE:___________________

WITNESS:____