

# 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.

Landerbrook Corporate Center  
5900 Landerbrook Drive #190  
Mayfield Heights, Ohio 44124  
Phone (440)461-2550  
Fax (440)461-5319

\_\_\_\_\_ 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. Receipts 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: \_\_\_\_\_