

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.

Hillcrest Medical Office Building
6770 Mayfield Road, Suite 415
Mayfield Heights, Ohio 44124
Phone (440)461-2550
Fax (440)461-3497

_____ 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: _____