CONSENT FOR RELEASE OF INFORMATION
(Please Print or Type)

I HEREBY AUTHORIZE ______________________ **OF** ______________________
Doctor or Facility — Street Address

______________ ______________ ______________
City — State — Zip Code

______________ ______________
Phone Number — Fax Number

TO RELEASE THE FOLLOWING INFORMATION OF PATIENT:

______________ ______________ ______ ______________ ______________
Last Name — First Name — Initial — DOB — Social Security #

______________ ______________ ______ ______
Street Address — City — State — Zip

____
Phone Number

Name(s) of the physician(s) who treated you: ______________________

____

Covering the period of ______________ **to** ______________
Date — **Date**

INFORMATION TO BE RELEASED:

__________ **All Records** Reason for Disclosure: ______________________

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INFORMATION TO BE RELEASED TO:

ERIESIDE MEDICAL GROUP, INC.
ATTN: ______________________ (Physicians Name)
38429 Lakeshore Boulevard
Willoughby, Ohio 44094
Phone - 440-946-9200
Fax – 440-946-1000

This consent will remain for ninety (90) days unless a specific date, event or condition is specified:

____

The facility, its employees and physicians are released from legal responsibilities or liabilities for the release of the above information to the extent indicated and authorized herein.

______________________ ______________
Signature of Patient — **Date of Signature**

______________________ ______________
Signature of Patient Representative — **Date of Signature**

(Medical records from other facilities in our possession will not be re-released)
(Allow 5-10 working days for request to be processed)
RUSH REQUEST MUST BE CLEARED BY MEDICAL LEGAL

PROHIBITATION OF REDISCLOSURE
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CPR PAR 2). YOU SHALL MAKE NO FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN AND INFORMED CONSENT OF THE INDIVIDUAL TO WHOM IT PERTAINS, OR AS OTHER WISE PERMITTED BY STATE AND FEDERAL LAW.