AUTHORIZATION TO RELEASE INFORMATION

I, the patient, am requesting my medical records from:

Dr.____________________________________
Address________________________________
City __________________State ____ Zip _______

Patient's Last Name ______________________ First Name _____________________
Date of Birth ______________________ Social Security # ______________________
Home Phone # _____________________

I hereby authorize disclosure of my protected health information as follows (Check all that apply)

___ Complete Medical Record
___ Records related only to the following date(s) of service _____________________
___ Other (describe) ____

Please send records to: (check one)

___ ASSOCIATES IN DERMATOLOGY, INC.
Dr. ________________________________
26908 Detroit Ave #103
Westlake, OH 44145
PH: 216-228-3900 FAX: 440-808-1718

___ Dr. _________________________________
6100 S. Broadway Ave. #101
Lorain, OH 44053
PH: 440-233-6665 FAX: 440-233-6531

___ Dr. _________________________________
18660 Bagley Rd. #204
Middleburg Hts., OH 44130
PH: 440-234-3104 FAX: 440-234-0316

Patient Signature ____

Patient Representative ___________________________**Relationship**______________

Date ___________________________

4/2005