CLEVELAND
SINUS INSTITUTE

Hillcrest Hospital
Atrium Medical Offices
6770 Mayfield Road,
Suite 441
Mayfield Heights, OH 44124

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize and request that Cleveland sinus Institute furnish a complete copy of my medical record to the following:

_____

(Physician/Facility Name)

_____

(City, State, Zip Code)

I am aware that there may be information in this medical record that relates to substance abuse, mental illness, or HIV/AIDS that is of a highly confidential level.

If entire medical record is not needed, please indicate what specific information is being requested:

_____

_____

I am aware that I can revoke this release at any time prior to the records being released to the above entity.

_____
Signature of Parent/Legal Guardian D.O.B. Date

_____ _____
Witness Date

** PLEASE BE ADVISED THAT WE REQUIRE EIGHT WEEKS NOTICE FOR A REQUEST TO RELEASE MEDICAL RECORDS **

** PLEASE FILL OUT FORM IN ITS ENTIRETY BEFORE RETURNING. INCOMPLETE INFORMATION MAY DELAY PROCESSING **

Records reviewed:_____
Sent:_____ _____
Sent by:_____