RAYMOND M. SEBALLOS, MD, INC.

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Strongsville, OH 44136

Authorization to Release Medical Records:

This document must be signed by the patient or person authorized by law.

I authorize _____ to release a copy of
(Healthcare Provider/Hospital or Institution)
my medical records for:

_____ _____
Name of Patient Date of Birth

_____ _____
Social Security Number Other identifying info if applies (other names)

Transmission by facsimile or electronic means authorized to expedite transfer of records.

_____
(Name)

_____
(Address)

_____
(Address)

_____
Phone # Fax #

The information will be used on my behalf for the following purpose(s):

_____

_____ _____
Date Signature of Patient or Person Authorized by Law