

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