North Coast Endoscopy, Inc.
9500 Mentor Avenue suite 380
Mentor, OH 44060
440-352-9400

Patient's Full Name: DOB:
Today's Date:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This form authorizes _____entity to disclose my medical

records relating to:

LAB □ XRAYS □ ENDOSCOPIES □ NOTES □ PATHOLOGY □

From Date: _____ To Date: _____

Address:_____

Phone Number:_____ Fax Number:_____

To be released to the following entity:

North Coast Endoscopy/Ahmad Ascha, M.D.
9500 Mentor Ave., Suite 380
Mentor, OH 44060
Fax: 440 352-9407
Tel: 440 352-9400

Patient/Guardian_____ Date_____

Name Printed: _____ If not patient, relationship_____

Witness:_____Date_____

Name Printed: _____