

North Coast Endoscopy, LLC.
9500 Mentor Avenue suite 340
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./Emily Carey, D.O.
9500 Mentor Ave., Suite 340
Mentor, OH 44060
Fax: 440 352-9407
Tel: 440 352-9400

Patient/Guardian _____ Date _____

Name Printed: _____ If not patient, relationship _____

Witness: _____ Date _____

Name Printed: _____