Michael T. Barkoukis, MD, FACS
Leonard H. Bernstein, MD, FACS
Michael T. Berte, MD, FACS
Lawrence A. Gervasi, MD, FACS
Martin A. Kosdrosky, MD, FACS
Tim A. Sidor, MD, FACS
J. Patrick Spirnak, MD, FACS
David S. Turk, MD, FACS
Carson Wong, MD, FRCSC, FACS
Holly K. Wyneski, MD

James Wagner, MD
Pathologist

Matthew A. Mates, PA-C
Physicians Assistant

Anna L. Myers, CNP
Certified Nurse Practitioner

W. John Stout, PA-C
Physician Assistant

6900 Pearl Road, 2nd Floor
Middleburg Heights, OH 44130
Phone: (440) 845- 0900
Fax: (440) 845-7355

970 E. Washington Street, Suite 5C
Medina, OH 44256
Phone: (330) 725-0600
Toll Free: (800) 589-7460
Fax: (330) 722-4457

12000 McCracken Road, Suite 451
Garfield Heights, OH 44125
Phone: (216) 581-0700
Fax: (216) 581-7558

SouthWest Urology @
Northern Ohio Regional
Cancer Center
5260 Smith Road
Brook Park, OH 44142
Phone: (440) 845-0900
Fax: (440) 845-7355

5319 Hoag Drive, Suite 240
Elyria, OH 44035
Phone: (440) 930-6060
Fax: (440) 695-1028

SouthWest Urology
Women's Connection
6900 Pearl Road, Suite 303
Middleburg Heights, OH 44130
Phone: (440)-887-2783
Fax: (440) 845-7034

www.southwesturology.com

SouthWest Urology

Advanced & Personalized Treatment For Your Entire Family

Patient Authorization to Release Medical Records

Patient Information	
Name (first, middle, Last)	Phone
Address	City, State, Zip
Last 4 digits of SS#	Date of Birth
Release Information From:	**Release Information To**
Name	Name
Address	Address
City,State,Zip	City,State,Zip
Phone	Phone
Fax	Fax

I hereby grant my permission for release of medical information relating to my care to the parties named here. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnosis. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization will expire in one year from the date of authorization, unless otherwise revoked in writing. This authorization does not include permission to release outpatient Psychotherapy notes.

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice. Any revocation will not apply to information that has already released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

☐ **The purpose of this release is for the continuing care and treatment of this patient.**

▭ Insurance ▭ Legal ▭ Transfer ▭ Personal

I specify this release includes:

_____ Complete Medical Record _____ Operative Reports _____ Radiology Reports
_____ Pathology Reports _____ Laboratory Reports _____ Discharge Summary
_____ Cardiac Reports _____ Emergency Dept. Reports _____ Office visits
_____ Other _____

Specify what information you authorize for the release to the provider listed above.

_____

To assist in the identification and location of my records, I am providing the following.

_____

_____ _____
Patient/Parent/Legal Guardian Signature Date Signed

If Signed by other than patient, state the relationship and reason for patient's inability to sign.

_____
Print Name of signer if other than patient.