RECORD RELEASE AUTHORIZATION

TO: _____
NAME OF PHYSICIAN

_____
ADDRESS SUITE

_____
CITY STATE ZIP CODE

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE RECORDS OF:

NAME:_____ DATE OF BIRTH: ____/_____/_____

FROM: _____/_____/_____ TO: _____/_____/_____
DATE DATE

TO:

☐ **SATNAM S. SANDHU, M.D.**

☐ **Main Office**
Meridia Southpointe Building A
4200 Warrensville Center Road, # 210
Warrensville Heights, OH 44122
Phone: (216) 491-7205
Fax: (216) 491-7206

☐ **RAFAEL GARCIA, M.D.**

☐ **Satellite Office**
St. Luke Medical Building
11201 Shaker Boulevard, #130
Cleveland, OH 44104
Phone: (216) 368 7449
Fax: (216)368-5623

REASON FOR RELEASE OF RECORDS: _____

SIGNATURE:_____ DATE: ____/_____/_____

WITNESS: _____ DATE: ____/_____/_____