Personal Best Health[SM], LLC

Matthew G Schuermann, MD
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Authorization for Release of Records

Transfer Records From:

Personal Best Health[SM]LLC
Matthew Schuermann, MD
6239 Cheviot Rd
Cincinnati, OH 45247

Transfer Records To:

_____
_____
_____
_____
_____

I hereby authorize and request that Personal Best Health[SM], LLC. release records of any treatment and/or examination rendered to me including: specific tests, reports, etc. including information relating to HIV status and/or treatment; information relating to mental health status and/or treatment; and information relating to drug or alcohol abuse:

- ❑ All records
- ❑ From _____ to _____.
  (Date) (Date)
- ❑ Specific tests and records _____
  _____

Patient Name: _____

Other Names Used: _____

Date of Birth: _____ Social Security #: _____

Patient Signature: _____

Witness: _____ Date: _____