

Matthew G Schuermann, MD

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Authorization for Release of Records

Transfer Records To:

Personal Best HealthSM LLC
 Matthew Schuermann, MD
 6239 Cheviot Rd
 Cincinnati, OH 45247

Transfer Records From:

I hereby authorize and request you to release to Personal Best HealthSM, LLC. the diagnosis and 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: _____