

**Authorization and Request**  
**For Release of Medical Records SEND TO**

Atta J. Ascf, DPM  
36001 Euclid Ave. Suite A-12  
Willoughby, Ohio 44094

I, the undersigned, hereby authorize release, and request COPIES produced of original medical records, laboratory and x-ray results/interpretations, as well as x-ray films in your possession, concerning care of treatment rendered to:

\_\_\_\_\_

Print patient name

\_\_\_\_\_

medical record/birth date/or ssn

\_\_\_\_\_

Signature & relationship to patient

\_\_\_\_\_

date

Your prompt response is greatly appreciated.