

General Medical Records Release

BRAHMS, COHN & LEB INC.

23250 MERCANTILE ROAD STE 100

BEACHWOOD, OHIO 44122

(216) 831-7855 - PHONE

(216) 831-5320 - FAX

Please read and sign below.

I hereby authorize Drs. Brahms Cohn & Leb Inc. and its appropriate personnel to retrieve any medical records from my previous physicians and/or testing facilities that may be considered necessary for my care.

This includes but is not limited to:

- \*Any Cleveland Clinic Physician or Hospital
- \*Any University Hospital Physician or Hospital
- \*Any other physician/facility listed below:

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Patient/Responsible Party Signature:

Date: