Record Release

Date: ____________________________

Re: ____DOB: ____

I, ____autorize the release of my medical

Records to:____

____

Records to include: ____

____

Please fax to:

Cornerstone Foot Care
Dr. Kimberly Ciccero, DPM
27900 Euclid Ave.
Euclid, OH 44132

Signature of Patient ____

Witness ____

13333 Lorain Ave., Cleveland, OH 44111
O. **216.941.3338** • F. **216.941.7505**

27900 Euclid Ave., Euclid, OH 44132
O. **216.731.3370** • F. **216.731.3880**

www.CornerstoneFootCare.com