Axelix Health Consulting, Inc
Olusegun Ogunlesi, MD
8587 East Avenue
Mentor, Ohio 44060

AHCI AXELIX HEALTH CONSULTING, INC.

Authorization to Release Medical Records

Patient:____ Birth Date____________________

Social Security No. (if applicable) ________________

PHYSICIAN RELEASING RECORDS:

Name__________________________________

Address________________________________

City___________________________________

Phone:________________ **Fax**:__________

PERSON TO RECEIVE RECORDS:

Name: Axelix Health Consulting, Inc. (Dr Ogunlesi)

Address: 8587 East Avenue____________________

City: Mentor, OH 44060______________________

Phone; 440-867-4800 **Fax**: 440-375-8842 __________

DATE(S) OF SERVICE: ____

MEDICAL INFORMATION TO BE SENT:

_____ Entire Medical Record, ***INCLUDING*** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire Medical Record, ***EXCLUDING*** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ **SELECTED PORTIONS OF THE MEDICAL RECORD ONLY:**

- ☐ History & Physical
- ☐ Progress Notes
- ☐ Consults
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Discharge Summary
- ☐ Billing Statements
- ☐ Other, please specify ________________

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I authorize medical information to be released as indicated above. I understand this release is effective until ____________, but that I may revoke my consent at any time by providing written revocation to the above named physician.

____ ____________________
Patient, Patient's Legal Guardian, or Personal Representative ***(PRINT Name)*** Date

____ ____________________
Patient, Patient's Legal Guardian, or Personal Representative ***(Signature)*** *Relationship to Patient (if applicable)*

____ ____________________
Witness ***(Signature)*** Date

Fax your completed MRR Form to 440-375-8842