

**BUCKEYE FAMILY HEALTH, LLC**  
LAURA E. MORGAN, M.D.  
MARK S. LEPI, M.D., VALERIE ZONA DO  
1548 Sheridan Drive, Suite 200  
Lancaster, OH 43130  
Phone: (740) 689-9860  
Fax: (740)-277-6270

**REQUEST FOR MEDICAL INFORMATION**

I, \_\_\_\_\_, being the patient, birth date \_\_\_\_\_,

social security # \_\_\_\_\_, hereby authorize the following physician:

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name of physician and practice name to receive records FROM

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physician mailing address, city, state, and zip

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**OR** - physician phone number

to release and furnish **Buckeye Family Health, LLC** the following medical information:  
cardiology reports, laboratory reports, radiology reports, progress notes and all other  
information.

**YOU ARE HEREBY AUTHORIZED AND REQUESTED  
TO PROVIDE THE INFORMATION REQUESTED**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE:** I understand this authorization extends to all or any part of records designated above which may include treatment for physical and mental illness, alcohol or drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and may include the results of an HIV test or the fact that an HIV test was performed. I expressly consent to release of information as designated above. I also understand this authorization extends to release of information via U.S. mail, overnight mail, telephone or facsimile machine (fax). This consent is valid for 60 days unless revoked by my written notice, provided records have not yet been released.