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MEDICAL RECORDS RELEASE (PLEASE PRINT)

I herby authorize the release of my medical information as indicated between the following parties:

REQUEST RECORDS FROM:

SEND RECORDS TO:

Cardiology Specialists of Dayton
 4160 Little York Road, Suite 20
 Dayton, OH 45414
 FAX (937) 454-9532

I authorize this release of information for: (mark all that apply)

- Consult/Second Opinion Legal (specify) _____
 Specialist Care Other (specify) _____
 Transfer of Care: Permanent / Temporary (dates) _____

Please indicate which of the following apply:

__ I will no longer hold Cardiology Specialists of Dayton responsible for my cardiac/Pacer/ coumcare or medication management.

__ This request is for information purposes only, however I will continue to be under the care of Cardiology Specialists of Dayton. I agree to be seen in the office as required by the physician. (office visits, pacer/ICD checks or coumadin management).

It is my desire that only the information checked below is to be released:

- DATES OF TREATMENT: _____
- Operative Reports Lab Progress Notes
 Medications Pacer/ICD Analysis Radiology Report
 Hospital Discharge H&P Other: _____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed. If the information specified above contains information related to drug and/or alcohol abuse, for psychiatric/mental condition, or HIV/AIDS; I am authorizing this information to be included.

SIGNATURE: _____ DATE: _____ WITNESS: _____
PRINT PATIENT'S NAME: (at time of care) _____
SS#: _____ **DATE OF BIRTH:** _____

RECORDS TO BE: MAILED PICKED UP FAXED Phone # _____
(PLEASE ALLOW 2 WEEKS FOR COMPLETION)

Date Completed: _____ By: _____

Notified: MR Dept Billing Pacer/ICD Coumcare

****COMPLETE TRANSFER OF CARE, FILE IN FRONT OF CHART****