FACSIMILE COVER SHEET

FROM: Norma
DATE: 11-20-09

TO: Tami
FAX NUMBER: 1-888-870-1729

THIS FAX IS ORIGINATING FROM OFFICE:

- [ ] **RAVENNA MEDICAL OFFICE**
  6847 North Chestnut Street
  Suite 100
  Ravenna, OH 44266
  Tel 330.297.6110
  Fax 330.296.0592
- [ ] **RAVENNA BILLING OFFICE**
  6847 North Chestnut Street
  Suite 230
  Ravenna, OH 44266
  Tel 330.297.2696
  Fax 330.297.3315
- [ ] **CEDAR PINE OFFICE**
  Cedar Pine Medical Building
  185 W. Cedar Street; Suite 100
  Akron, OH 44307
  Tel 330.376.0500
  Fax 330.376.9900
- [ ] **SUMMA OFFICE**
  95 Arch Street; Suite 300
  Akron, OH 44304
  Tel 330.253.8195
  Fax 330.253.0853
- [x] **SUMMA OFFICE**
  95 Arch Street; Suite 350
  Akron, OH 44304
  Tel 330.376.7000
  Fax 330.376.1066
- [ ] **BARBERTON OFFICE**
  201 Fifth Street, Suite 16
  Barberton, OH 44203
  Tel 330.745.7634
  Fax 330.745.0910

NUMBER OF PAGES INCLUDING COVER SHEET: 2

Please contact me immediately if you have not received the total number of pages or if there is any problem with this transaction.

Release form —
Please fill out & sign;
then fax to 330-253-0853
Attn: DONNA.

Tx.
Norma

NOTE: This message may contain information that is privileged, confidential and not for disclosure under applicable law. If the reader of this transmission is not the intended recipient, or the person directly responsible for the delivery of this message to the recipient, you are hereby notified that any dissemination, distribution or communication of this message is strictly prohibited. If you have received this message by mistake, please telephone me immediately and mail (via the U.S Postal Service) the original message to us. Thank you.

___95 Arch Street, Ste 350/300
Akron, Ohio 44304
Phone: 330-376-7000
Fax: 330-376-1066
Phone: 330-253-8195
Fax: 330-253-0853

___RPC. 6847 N Chestnut Ste. Ste 100
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___85 W. Cedar St. Ste 100
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Phone: 330-376-0500
Fax: 330-376-9900

___201 Fifth Street, NE, Suite 16
Barberton, Ohio 44203
Phone: 330-745-7634
Fax: 330-745-0910

Authorization for Release of Information

Patient: ______________________ ______ ______________________
First Name M.I. Last Name

______________________ ______ ______________________
Address: Street City/State/Zip

Date of Birth______________________ Social Security #______________________

I hereby authorize and request __ Northeast Ohio Cardiovascular Specialists, Inc. a Division of Summa Physicians Inc. __ Other Provider ______________________ to provide:

______________________ ______________________
Receiving Organization/Agency/Person Street Address

______________________ for the purpose of ______________________
City /State/Zip (Purpose of discloser of Information)

(Please specify by checking appropriate line)

____ History & Physical (last 2)

____HIV Testing and Treatment Information

____ Progress Notes

____Mental Health Records

____ EKG's (most current)

____Diagnostic Reports (most current)

____Alcohol & Drug Records

____ Device Reports (most current)

____Operative Reports (last one)

____ Labs/anticoagulation (last 2)

____Other (Specify):______________________

I understand that I have the right to inspect and copy the information to be disclosed.
I understand that this authorization will expire in six months.
I understand that I may revoke this authorization at any time by notifying NEOCS a Division of SPI but if I do it won't have any affect on any actions they took before they received the revocation.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

X______________________ ______________________
Signature of Patient Date

X______________________ ______________________
Signature of Legal Representative (Applicable) Date

______________________ X______________________
Legal Basis on which consent is given by Representative Witness