The Heart Group

A steady pulse of excellence.

___ 95 Arch Street, Ste 350
Akron, Ohio 44304
Phone: 330-376-7000
Fax: 330-376-1066

___ 3963 Loomis Parkway
Ravenna, Ohio 44266
Phone: 330-297-6110
Fax: 330-296-0592

___ 185 W. Cedar St. Ste 100
Akron, Ohio 44307
Phone: 330-376-0500
Fax: 330-376-9900

__ 546 Winter St. Ste 110
Wooster, Ohio 44691
Phone: 330-345-3622
Fax: 330-345-4530

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 __The Heart Group, Inc or__ Other Provider _____ to provide:

_____ _____
Receiving Organization/Agency/Person Street Address

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

All information in my medical record EXCLUDING: (Please specify by checking appropriate line)

____ History & Physical

____ Progress Notes

____Diagnostic Reports

____Operative Reports

____HIV Testing and Treatment Information

____Mental Health Records

____Alcohol & Drug Records

____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 The Heart Group Inc. , but if I do it won't have any affect on any actions they took before they received the revocation.

X_____ _____
Signature of Patient *Date*

X_____ _____
Signature of Legal Representative (Applicable) Date

_____ X_____
Legal Basis on which consent is given by Representative *Witness*

Revised 5-8-06