

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: _____

I hereby authorize the release of my medical records to:

Northwest Ohio Cardiology Consultants

- | | | |
|--------------------------|---|---------------------|
| <input type="checkbox"/> | 2940 N. McCord Rd., Toledo, OH 43615 | Fax: (419) 842-3046 |
| <input type="checkbox"/> | 770 Riverside Ave., #106, Adrian, MI 49221 | Fax: (517) 266-0956 |
| <input type="checkbox"/> | 1037 Conneaut Ave., #202, Bowling Green, OH 43402 | Fax: (419) 353-9901 |
| <input type="checkbox"/> | 715 S. Taft Ave., #195, Fremont, OH 43420 | Fax: (419) 333-9537 |
| <input type="checkbox"/> | 11-600 State Route 424, Napoleon, OH 43545 | Fax: (419) 592-0563 |
| <input type="checkbox"/> | 2702 Navarre Ave., #310, Oregon, OH 43616 | Fax: (419) 691-0296 |
| <input type="checkbox"/> | 500 E. Pottawatamie St., Tecumseh, MI 49286 | Fax: (517) 423-5567 |
| <input type="checkbox"/> | 734 S. Shoop Ave., Wauseon, OH 43567 | Fax: (419) 337-9994 |
| <input type="checkbox"/> | _____ | Fax: _____ |

Patient Name _____ DOB _____
(Please print)

Address _____

Patient Signature _____

Witness Signature _____

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