AUTHORIZATION TO TRANSFER RECORDS

Patient Name:	**Date of Birth:**
Patient Address:	
Phone:	

Name and address of health provider or entity to release the information:
Auburn Cardiology Associates, 281 Grant Avenue, Auburn, NY 13021 PH: 315-253-4459 Fax: 315-253-4609

I hereby authorize you to transfer my medical records:

Name and address of health provider or entity to send information:	
Phone: 315-701-2170	**Fax: 315-701-2185**

Signature of Patient **Date**