

Pulmonary Medicine of Dayton, Inc.  
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**Pulmonary & Critical Care Medicine**

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**Authorization For Transfer of Medical Records**

Expires: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to transfer my medical records and any other medical information necessary for the purpose of continuing medical care and/or \_\_\_\_\_. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug and alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions. Records to be released to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information Requested**

- |   |   |
|---|---|
| <input type="checkbox"/> History/Physical         | <input type="checkbox"/> Physician's Letters            |
| <input type="checkbox"/> Pulmonary Function Tests | <input type="checkbox"/> EKG Interpretations            |
| <input type="checkbox"/> Skin Testing/PPD         | <input type="checkbox"/> Copies of <b>Entire Record</b> |
| <input type="checkbox"/> X-Ray Reports/CT Scans   | <input type="checkbox"/> Other-Please Specify:          |

I understand that I am responsible for its content and will in no way hold the above responsible for the disclosure of information revealed in my medical records. I acknowledge the right to revoke this authorization in writing according to Pulmonary Medicine of Dayton, Inc.'s Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Staff Member Completing Authorization