Pediatric Associates, Inc.

DO NOT SEND ENTIRE MEDICAL RECORD UNLESS REQUESTED

I AM REQUESTING ONLY THE FOLLOWING INFORMATION TO BE SENT TO PEDIATRIC ASSOCIATES:

☐**IMMUNIZATION RECORDS** ☐ **ALL MEDICAL RECORDS**

☐**GROWTH CHARTS** ☐ **PROBLEM LIST**

☐**RECORDS FOR DATES OF SERVICE** _____ **TO** _____

INFORMATION IS TO BE RELEASED FOR THE PURPOSE(S): **(CHECK ALL THAT APPLY)**

☐ **CONTINUITY OF CARE** ☐ **MAKING A REFERRAL** ☐ **OTHER** _____

FOR PATIENT:
Last Name, Middle Name, First Name _____ **DATE OF BIRTH**_____
PLEASE FILL OUT A SEPERATE FORM FOR EACH CHILD
FATHER'S NAME:_____

MOTHER'S NAME:_____

ADDRESS:_____
STREET ADDRESS CITY STATE ZIP

PLEASE SEND RECORDS TO: **(CHECK OFFICE REQUEST NEEDS TO COME TO)**

☐PEDIATRIC ASSOCIATES, INC.
1021 COUNTRY CLUB RD SUITE A
COLUMBUS, OHIO 43213
Fax: (614) 434-2701

☐PEDIATRIC ASSOCIATES, INC.
4595 TRUEMAN BLVD.
HILLIARD, OH 43026
Fax: (614) 529-2370

☐PEDIATRIC ASSOCIATES, INC.
905 OLD DILEY ROAD
PICKERINGTON, OH 43147
Fax: (614) 863-7388

☐PEDIATRIC ASSOCIATES, INC.
7420 GOODING BLVD SUITE 100
DELAWARE, OH 43015
Fax: (740) 657-8100

PERSON/ORGANIZATION AUTHORIZED TO RELEASE INFORMATION:
Name: _____
Street Address: _____
City, State & Zip Code: _____
Phone Number: _____
Fax Number: _____

I hereby authorize the use and disclosure of any and all medical records requested above (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information). This authorization and request is fully understood and is made voluntary on my part. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I release the above named facility of any legal liability that may arise from release of the information requested. This authorization will expire automatically 90 days from the date on which it was signed.

DATE:_____ **SIGNATURE OF PARENT:**_____

DATE:_____ **SIGNATURE OF WITNESS:**_____