## 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	г
□RECORDS FOR DATES OF SERVICE	Ето	
INFORMATION IS TO BE RELEASED	FOR THE PURPOSE(S): (CHE	CK ALL THAT APPLY)
☐ CONTINUITY OF CARE ☐ MAKI	NG A REFERRAL   OTHER	
FOR PATIENT: Last Name, Middle Name, First Name PLEASE FILL OUT A SEPERATE FORM FOR E FATHER'S NAME:	ACH CHILD	
MOTHER'S NAME:		*
ADDRESS:		
STREET ADDRESS PLEASE SEND RECORDS TO:	CITY (CHECK OFFICE REQUEST	STATE ZIP F NEEDS TO COME TO)
021 Country Club Rd., Ste. A olumbus, OH 43213	Pediatric Associates, In 4595 Trueman Blvd. Hilliard, OH 43026 □Fax: (614)529-2370	Pediatric Associates, Ir 905 Old Diley Rd. Pickerington, OH 4314  Fax: (614)863-7388
Pediatric Associates, 7420 Gooding Blvd., Delaware, OH 43015	Ste. 100	Pediatric Associates, Inc. 7750 Diley Rd. Canal Winchester, OH 43110 □Fax: (614)837-7335
PERSON/ORGANIZATION AUTHORIZED Name:	TO RELEASE INFORMATION:	
City, State & Zip Code:		
I hereby authorize the use and disclosure of substance abuse, psychiatric/mental healt is made voluntary on my part. I have the r	h information or HIV/AIDS information ight to revoke this authorization in we e above named facility of any legal lia	ted above (including but not limited to records of any on). This authorization and request is fully understood an riting at any time except to the extent that action has ability that may arise from release of the information on which it was signed.
DATE:SIG	NATURE OF PARENT:	
DATE:SIG	NATURE OF WITNESS:	
	www.kidzdoc.com	