

Mid-Ohio Pediatrics and Adolescents
595 Copeland Mill Rd
Westerville OH 43081
(614)899-0000 (614)899-0524 fax

Authorization to Release Medical Records to Mid-Ohio Pediatrics and Adolescents, Inc.

Patient First Name _____ Patient Last Name _____

Patient Date of Birth ___/___/___ Parent/Guardian or Patient Contact Number (____) _____

Patient's Address _____

City _____ State _____ Zip Code _____

Information Requested (check one)

___ Immunizations Only ___ Basic Medical Records ___ Complete Chart ___ Other _____

(Basic Medical Records include Immunization Records, Last 2 Well Visits and Growth Charts)

Please transfer the requested medical records FROM

Name	Address		
Phone Number	City	State	Zip
Fax Number			

The records can be sent by

_____ Mail _____ Fax to (614) 899-0524

I understand there may be a fee associated with the transfer of these medical records. I can be contacted at the above number to collect any payment necessary before the records will be transferred to the new physician's office.

Parent/Guardian Name (please print) _____

Patient or Parent/Guardian Signature _____ Date _____

(If over 18 years old, the patient must sign)

Relationship to Patient _____