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

Acct # _____

Medical Records Request

Patient First Name _____ Patient Last Name _____

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

Reason for Records Request

____ Immunization Records for School/Sport/Camp
____ Specialist review; Not transferring out of practice
____ Moving out of the area or transferring to another Physician
____ Other _____

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)

Mid-Ohio Pediatrics will contact you at the above listed phone number to collect payment due for transferring of records (if applicable). Once payment is received please allow up to 2 weeks for the records to be transferred.

Please release medical records from Mid-Ohio Pediatrics and Adolescents, Inc. to

Name	Address
Phone	City State Zip

Please send record by

_____ Mail _____ Pick up at our office by _____
(Name of Authorized person to pick up the medical records)

Parent/Guardian Name (please print) _____

I hereby authorize Mid-Ohio Pediatrics and Adolescents, Inc. to release the health information indicated above that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.

Patient or Parent/Guardian Signature _____ Date _____
(If over 18 years old, the patient must sign)

Relationship to Patient _____

Office Use Only

Received by _____ Payment of $_____ Paid by _____ Date Paid _____

Date mailed, faxed or picked up _____