Mid-Ohio Pediatrics and Adolescents
465 N Cleveland Ave. Suite 200
Westerville OH 43082
(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 Fax Number	City State Zip

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 _____