AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, THE PARENT/LEGAL REPRESENTATIVE
Please Print

HEREBY AUTHORIZE:

Previous Practice Name: _____
Please Print

Doctor's Name: _____
Please Print

Address: _____
Please Print

Phone #: _____ **Fax:** _____

PLEASE RELEASE MEDICAL RECORDS FOR THE FOLLOWING PATIENTS:

Name: _____ Date of Birth: _____ / _____ / _____

Name: _____ Date of Birth: _____ / _____ / _____

Name: _____ Date of Birth: _____ / _____ / _____

FOR THE PURPOSES OF CONTINUING MEDICAL CARE, TO THE PHYSICIANS OF NORTHWEST PEDIATRICS, INC.

Located at:

❑ NORTHWEST PEDIATRICS
7275 Sawmill Road
Dublin, OH 43016
Ph: (614) 766-6321
Fax: (614) 766-0193

❑ NORTHWEST PEDIATRICS
3230 Northwest Boulevard
Upper Arlington, OH 43221
Ph: (614) 457-6461
Fax: (614) 457-3819

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human immunodeficiency Virus (HIV). It may also included information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based upon this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: (If I do not specify an expiration date, event or condition, this authorization will expire in one year.) _____

Signature: _____
Patient, Parent, Guardian, or Legal Representative of Patient **Date**

Relationship to the Patient: _____ **Phone:** _____