Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM WESTERVILLE PEDIATRIC SPECIALISTS, INC.

1) _____
Patient's Name ***Date of Birth***

2) _____
Patient's Name ***Date of Birth***

3) _____
Patient's Name ***Date of Birth***

4) _____
Patient's Name ***Date of Birth***

Records sent to the following: _____

Address: _____

_____

I hereby authorize and request the release of the records and information to the entity identified above.

I also authorize Westerville Pediatric Specialists, Inc. to furnish a complete copy of the medical record, medical information, (known as PHI) and related data for the above identified patient(s) from _____(date) to _____(date). I am aware that there may be information in this medical record that relates to substance abuse, mental illness or HIV/Aids that is of a highly confidential level. I am also aware that any medical records transferred to Westerville Pediatric Specialists, Inc. from another physician cannot be forwarded to the above-named person. I am aware that I can revoke this release at any time prior to the records being released to the above-named entity and that this release is valid for a limited time of 90 days. In addition, I understand that I will be charged a $45.00 fee per patient to process this medical record request.

Signature of Parent/Legal Guardian: _____Date_____

Witness _____

For Office Use ONLY: Date records sent _____ By:_____ Fee collected_____