Medical Record Release Authorization

Associated Pediatrics, Inc.
614-882-9460/fax 882-9802

I the undersigned, Authorize (holder of requested records):

□ Associated Pediatrics
801 Eastwind Drive
Westerville OH 43081

□ _____
_____
_____

To release information from the records of:

Patient/s: Date of Birth:

_____ _____
_____ _____
_____ _____
_____ _____

Reason for request:
___Moved out of area-NEW ADDRESS:_____phone#_____
___ Over 18yr. of age ** *MUST BE SIGNED (AUTHORIZED) BY PATIENT.* **
___Change of Insurance to_____
___ Other (Please explain)

_____

Information to be released includes ANY & ALL:

Medical Records & Films
Tests, including Lab, X-ray & Diagnostic
Psychiatric Records
HIV/AIDS Information
Alcohol and/or Drug Abuse Records
Sexually Transmitted Disease Information

Excluded Information:_____

Information to be released to:

□ _____
_____
_____

□ Associated Pediatrics
801 Eastwind Drive
Westerville, OH 43081
Fax: 614-882-9802

I understand that a photocopy of this authorization is to be considered valid as the original. This authorization is valid for six months from the date of signature unless revoked in writing by myself. However, I do understand that I may not revoke this authorization, to the extent that you have acted in reliance upon this authorization prior to the date I revoke this authorization.
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

X_____ _____
Signature of Parent/Guardian/Patient Date

Day time phone #_(_____)_____

Medical Records Fee Notice

In order to expedite your record release, please make sure to include the copy fee of
$15.00 PER MEDICAL RECORD along with your request.

For Credit Card payments please complete: Amount $ _____

Acct # _____ exp date_____

Signature_____