OLENTANGY PEDIATRICS, INC. RECORD RELEASE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____DATE OF BIRTH_____

ADDRESS:_____REQUEST DATE:_____

PLEASE BE ADVISED THAT THERE IS A FEE FOR RECORD COPYING. OUR OFFICE WILL CONTACT YOU PRIOR TO RELEASING YOUR RECORDS TO ADVISE YOU OF YOUR FEE.

I AUTHORIZE OLENTANGY PEDIATRICS, INC. TO PROVIDE THE FOLLOWING MEDICAL RECORDS:

YES___NO___ ENTIRE MEDICAL RECORD (INCLUDING HIV, AIDS, ALCOHOL OR DRUG ABUSE, AND MENTAL HEALTH RECORDS)

YES___NO___ OPERATIVE NOTES YES___NO___ PHYSICIAN PROGRESS NOTES

YES___NO___ XRAY RESULTS YES___NO___LAB RESULTS

YES___NO___OTHER_____

PURPOSE OF RELEASE: The protected information will be used/disclosed for the following reason:

___Ongoing treatment and care ___Specialist Referral ___Leaving Practice ___Other

Please send records to:

NAME_____ ADDRESS_____

PHONE: _____ _____

_____

This authorization is good for 90 days from date signed by parent or legal guardian.

Signature of Patient or Legal Guardian

Date: _____

PLEASE REMIT SIGNED FORM TO OLENTANGY PEDIATRICS, INC., 4775 KNIGHTSBRIDGE BLVD. #207, COLUMBUS, OH, 43214. FORM MAY ALSO BE FAXED TO 614-442-1070. PLEASE ALLOW 5 BUSINESS DAYS TO ACCOMMODATE YOUR REQUEST. THANK YOU.