OLENTANGY PEDIATRICS, INC. RECORD RELEASE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ REQUEST DATE:_____

_____

_____

I AUTHORIZE _____ TO PROVIDE THE FOLLOWING MEDICAL RECORDS:

YES__NO__ ENTIRE MEDICAL RECORDS (INCLUDING HIV, AIDS, ALCOHOL OR DRUG ABUSE, AND MEDICAL HEALTH RECORDS)

YES__NO__ OPERATIVE NOTES YES__NO__PHYSICIAN PROGRESS NOTES

YES__NO__ OTHER _____

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

_____

Please send records to:

OLENTANGY PEDIATRICS, INC.
4775 KNIGHTSBRIDGE BLVD, STE 207
COLUMBUS, OH 43214
P: (614) 442-5557
F: (614) 442-2133

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

_____ _____

Signature of Patient or Legal Guardian Date