Westerville Pediatric Specialists, Inc.
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Ilona B. Albrecht, D.O., F.A.A.P. Michael J. Leymaster, M.D., F.A.A.P. Kathleen M. Wodarcyk, M.D., F.A.A.P.
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Authorization for Release of Medical Records

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Records sent to the following : _____

Address: _____

_____

I hereby authorize and request that you release the records and information to the entity identified above:

I hereby authorize Westerville Pediatric Specialists, Inc. to furnish a complete copy of the medical record, medical information, also known as PHI and related data for the above identified person **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.** I am also aware that effective June, 2017, I will be charged a $30.00 fee to process this medical record.

Signature of Parent/Legal Guardian: _____

Witness _____

For Office Use ONLY:

Records Sent:_____ **By:**_____

Fee charged/collected: $_____/_____