AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name & address of party to send medical records

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The undersigned understands and acknowledges that:

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and discloses (releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving of this authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by Federal privacy law.

____ Date: ____________________

Signature of parent or legal guardian

Child's name: ______________________________ Date of birth: ____________________

Child's name: ______________________________ Date of birth: ____________________

Child's name: ______________________________ Date of birth: ____________________

Child's name: ______________________________ Date of birth: ____________________

CIRCLE THE LOCATION THAT RECORDS SHOULD BE MAILED TO:

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

or

Sunbury Mills Pediatrics
450 South Miller Drive, Suite 100
Sunbury OH 43074
740/965-6369

IMMUNIZATION RECORD *ONLY* MAY BE FAXED TO:

Westerville
614/508-2233

Sunbury
740/965-6371

Description of information to be released/disclosed (circle all that apply):

☐ All medical records ☐ Immunization record

☐ Other: ____

Purpose or need for release (circle applicable purpose):

☐ Continuation of medical care ☐ Payment of insurance claim ☐ Legal

☐ Personal ☐ Other: ____________________________________

This authorization is in effect for six (6) months from date of signature, or until: ____/____/____

Printed Name: ____

A copy of this authorization will be made available upon request to the individual granting the authorization.