Olentangy Pediatrics, Inc.

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME:_____ DATE OF BIRTH_____

PHONE NUMBER:_____ REQUEST DATE:_____

(If you have a change of address or phone number, please contact our office to update)

I request and authorize **Olentangy Pediatrics** to **receive/release** healthcare information of the patient named above **to/from**: (please circle one)

Name/Office:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Fax number: _____ Phone Number: _____

This request and authorization replies to:

- ☐ Healthcare information relating to the following treatment, condition or dates:

  _____
- ☐ Healthcare information from the last 2 years
- ☐ All Healthcare Information (INCLUDING HIV, AIDS, ALCOHOL OR DRUG ABUSE, AND MENTAL HEALTH RECORDS)
- ☐ Other:

  _____

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

- ☐ Ongoing treatment and care or Specialist Referral
- ☐ Leaving Practice
- ☐ Age-Out of Practice
- ☐ Other: _____

Signature of Patient or Legal Guardian Date

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

Office email address: opedsforms@rrohio.com

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