

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, the **PARENT/LEGAL REPRESENTATIVE**

HEREBY AUTHORIZE:

Practice Name: _____

Phone #: _____ Fax #: _____

TO RELEASE COPIES THE MEDICAL RECORD OF:

Patient(s):

Name: _____ Date of Birth: ____/____/____

Name: _____ Date of Birth: ____/____/____

Name: _____ Date of Birth: ____/____/____

Name: _____ Date of Birth: ____/____/____

Name: _____ Date of Birth: ____/____/____

FOR THE PURPOSE OF CONTINUING MEDICAL CARE, to the Physicians of
Northwest Pediatrics, Inc. located at:

_____ **NORTHWEST PEDIATRICS**
7275 Sawmill Road
Dublin, OH 43016
Ph: (614) 766-6321
Fax: (614) 766-0193

_____ **NORTHWEST PEDIATRICS**
3230 Northwest Boulevard
Upper Arlington, OH 43221
Ph: (614) 457-6461
Fax: (614) 547-3819

Parent/Legal Representative Signature

Date