Northwest Pediatrics, Inc.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ______________________________ , THE PARENT/LEGAL REPRESENTATIVE

HEREBY AUTHORIZE:

Previous Practice Name: ______________________________

Address: ______________________________

Phone #: ____________________ Fax #: ____________________ TO RELEASE

MEDICAL RECORD FOR:

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 Pediatric, 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) 457-3819

______________________________ ____________________

Parent/Legal Representative Signature Date