REQUEST OF PRIVATE HEALTHCARE INFORMATION

Date: _____

ATTN: Medical Records Department of: _____

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

Patient's Name: _____

Date of Birth: _____

Address: _____

_____

Please send the Records to:

West Ohio Pediatrics
725 S Shoop Ave Suite 204
Wauseon, OH 43567
Phone: 419-335-3333
Fax: 419-337-7845

The patient will, if necessary, tender payment for the cost of copying said records.

_____ _____
Patient/Parent/Guardian Signature Date

Thank You in advance for your help and cooperation in this matter.