Olentangy Pediatrics, Inc.

Eileen M. Maher, M.D. S. Randall Brown, M.D. Irene P. Koesters, M.D. Autumn M. O'Brien, M.D. Emily T. Ferguson, M.D.
Mitchell R. Camp, M.D. Jacqueline Nicodemo, M.D. Rachel Pratt, M.D. Claire S. Ackerman, Ph.D. Heather K. Guthrie, Ph.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name(s): _____

Date of Birth(s): _____

Address: _____

Phone Number: _____ Email Address: _____

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

Name: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

Purpose of release:

- ☐ Leaving Practice
- ☐ Aging out of practice
- ☐ Personal Record
- ☐ Specialist Referral
- ☐ Other: _____

Information to be released: for the record (s) selected above, please specify the content to be released in the area below.

- ☐ Complete record
- ☐ Last 2 years
- ☐ Other: _____

Signature of Patient, Parent or legal guardian Date

This authorization is good for 90 days from date signed by patient, parent, or legal guardian.
Fee will vary depending on request, please contact our office for more information.
Office Email: opedsforms@gmail.com

4775 Knightsbridge Blvd., Columbus, Ohio 43214 • 614-442-5557 • Fax 614-442-1070