Pediatric Associates, Inc.

Request for Medical Records +/or Immunization Records

I AM REQUESTING: (Check the appropriate box)

☐ **Medical Records** ☐ **Immunization Records**

The Specific Information that should be disclosed is: (Please give dates of service if possible.)

_____

_____

Unless you sign here, no information about alcohol/substance abuse, HIV/Aids, or Mental Health will be disclosed:_____

This Authorization Expires on:_____, 200_____
Month/Date Year

FOR:

Patient's Name:_____ Date of Birth:_____
Every patient must have a separate request.

Father's Name: _____

Mother's Name: _____
Please list all last name(s) of parents. Charts are filed under last name of parents, and are subject to change.

BILL TO:_____
Address City State Zip

PLEASE SEND RECORDS TO:

☐ Pediatric Associates, Inc.
1021 Country Club Rd. Suite A
Columbus, Ohio 43213

☐ Pediatric Associates, Inc.
3720 Ridge Mill Drive
Columbus, Ohio 43026

☐ Pediatric Associates, Inc.
1310 Hill Road North
Pickerington, Ohio 43147

☐ Patient/Physician Address:
_____
_____
_____
_____

☐ These records have been scanned by Pediatric Associates and returned to Parent for keeping.

There is no notary on staff. We do not send records by Certified Mail.

Fees for copies: Federal and State laws permit a fee to be charged for the copying of patient records. This facility has contracted with Smart Document Solutions to make copies. You may be required to prepay for the copies; if not, then your copies will be mailed along with an invoice.

Date:_____Signature of Witness:_____

Date:_____Signature of Parent:_____

Willard B. Fernald, M.D., Em. *www.kidzdoc.com* Malcolm L. Robbins, M.D., Em.

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1310 Hill Road N. • Pickerington, Ohio 43147 • 614-864-3222 • Fax 614-863-7388
3720 Ridge Mill Drive • Hilliard, Ohio 43026 • 614-529-0771 • Fax 614-529-2370