Springdale-Mason
PEDIATRIC ASSOCIATES, INC.

11360 Springfield Pike
Cincinnati, Ohio 45246
Phone: 513-771-1613
Fax: 513-771-4735

7450 Mason-Montgomery Rd.
Mason, Ohio 45040
Phone: 513-459-1615
Fax: 513-459-0375

PLEASE TRANSFER MY CHILDREN(S) MEDICAL RECORDS:

FROM: _____ TO: _____

_____ _____

_____ _____

The transfer should include the following patient's records:

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

The undersigned hereby authorizes the release of the following portions of the medical records for the above named patient(s):
____ Immunization Records
____ Entire medical record from _____ to _____
____ The following specific portion of the medical records _____

Reason for transfer: _____

Parent's Name: _____

Parent's Address: _____

Parent's Phone: _____

I understand that I may revoke this release at anytime, in writing, but the request should remain valid until revoked or upon the expiration date of 60 days, whichever comes first. I understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS or AIDS-related information may also be released.

_____ _____
Signature Date of Signature

_____ _____
Relationship (if other than patient) Witness

Released by: _____ on _____