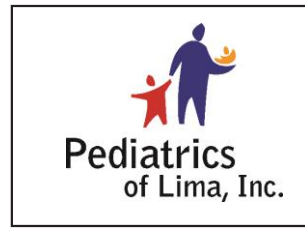


Pediatrics of Lima, Inc

830 W. High St, Suite
102 Lima, OH 45801
(419) 222-4045
Fax: (419) 228-5665



I hereby authorize and request that, for the child(ren) listed below, the following medical records be released (choose all that apply) from (choose where):

<input type="checkbox"/> All Records	<input type="checkbox"/> SC Certificate of Immunization	<input type="checkbox"/> Complete Vaccine Record (non-certified)
<input type="checkbox"/> _____ Results	<input type="checkbox"/> Physician Notes	<input type="checkbox"/> Payment History/Account Information
<input type="checkbox"/> Include old records from previous primary care physician(s)	<input type="checkbox"/> Other: _____	

From: Pediatrics of Lima, Inc.
 From another facility: Name: _____
 Location/Ph#: _____

for the following dates: from _____ to _____ for the purpose of: transfer personal copy release

The information is to be released to the following person or facility (choose):

Pediatrics of Lima, 803 W. High St., Suite 102, Lima, OH 45801, Fax 419-228-5665

Transfer or Release information to:
 Facility: _____ (addressee)
 Address: _____ City/St/Zip _____
 Phone: () _____ Fax: () _____
 Attention to: _____ Email _____

Personal Copy to be released to: (Full name(s)) _____ (ID may be required)

The information is to be (choose): (Charges may apply)

<input type="checkbox"/> Mailed to the current home address	<input type="checkbox"/> Mailed to the above address	<input type="checkbox"/> Emailed (we cannot guarantee security)
<input type="checkbox"/> Faxed to the above number	<input type="checkbox"/> Picked up in person	<input type="checkbox"/> Discussed with above named party

Child(ren)'s Name(s):	Date(s) of Birth:	Sex:
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

I understand that there may be an associated charge for providing these records.

Parent/Legal Guardian Printed Name: _____ Signature: _____ Date: _____

**

**This authorization expires in 90 days from the above date.

If faxed, this fax transmission contains information which is confidential and/or privileged. This information is intended for use only by the addressee indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited, and that any misdirected or improperly received information must be returned to this office immediately. Your cooperation in phoning us about an erroneous receipt is requested. Thank you.