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):

- o All Records
- o _____Results
- o SC Certificate of Immunization
- o Physician Notes
- o Complete Vaccine Record (non-certified)
- o Payment History/Account Information
- o Other: _____

Include old records from previous primary care physician(s)

From:

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

for the following dates: from_____ to_____ for the purpose of: o transfer o personal copy o release

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

- o **Pediatrics of Lima**, 803 W. High St., Suite 102, Lima, OH 45801, Fax 419-228-5665
- o Transfer or Release information to:
  Facility: _____ (addressee)
  Address: _____ City/St/Zip
  _____
  Phone: ( ) _____Fax: ( ) _____
  Attention to:_____Email_____
- o Personal Copy to be released to: (Full name(s)) _____ (ID may be required)

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

- o Mailed to the current home address
- o Mailed to the above address
- o Emailed (we cannot guarantee security)
- o Faxed to the above number
- o Picked up in person
- o Discussed with above named party

Child(ren)'s Name(s):	**Date(s) of Birth:**	**Sex:**
_____		o M o F
_____		o M o F
_____		o M o F
_____		o M o 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.