

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize: _____
located at: _____
to release my children(s) medical record(s) including progress notes, immunization records, growth charts, consultations, hospitalizations, and laboratory results to:

**Muddy Creek Pediatrics
6400 Thornberry Ct., Ste 610
Mason, Ohio 45040
Phone (513) 398-3900 Fax (513) 398-4950**

Children's names

Birth Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The release of this information is for the purpose of (i.e. Transfer of records):

I understand that the health information that will be used and disclosed as a result of this authorization may include medical records or treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse, and may also include records or treatment for sexually transmitted disease, HIV, AIDS, or AIDS-related information.

Signature of Patient or Legal Representative

Date

Relationship to patient if signed by Legal Representative