

CHILD CARE CONSULTANTS, INC.

Practice Limited to Pediatrics

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AUTHORIZATION TO TRANSFER MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Transfer records to the following:

Child Care Consultants, Inc. 5957 Cleveland Avenue Suite A Columbus, OH 43231	Child Care Consultants, Inc. 111 Inah Avenue Columbus, OH 43228	Other: _____ _____ _____
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Specific Authorization: I specifically authorize the release of all medical information relating to me including, but not limited to the following categories protected by state or federal law: (1) Substance Abuse (drug or alcohol) treatment, (2) Mental Health treatment and (3) HIV/AIDS related information, if such information is in my records.

I do not give permission for any other use or redisclosure of this information.

Validity: I understand that this release will automatically expire one year from the date of my signature, and that I may revoke this release by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorized the release of information as indicated about.

Patient/ Legal Guarding: _____ Date: _____

Patient's Address: _____

