

# CHILD CARE CONSULTANTS, INC.

*Practice Limited to Pediatrics*

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WEST

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NORTH

5957 CLEVELAND AVE, SUITE A  
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(614)523-1666 \* FAX (614)523-1490

## AUTHORIZATION TO TRANSFER MEDICAL RECORDS

### \*\*FROM CHILD CARE CONSULTANTS\*\*

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Transfer records from the following: (Please circle one)

(NORTH OFFICE) :

Child Care Consultants, Inc.  
5957 Cleveland Avenue  
Suite A  
Columbus, OH 43231

(WEST OFFICE) :

Child Care Consultants, Inc.  
111 Inah Avenue  
Columbus, OH 43228

To: Office / Other : \_\_\_\_\_

Address : \_\_\_\_\_

Phone # : \_\_\_\_\_

**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 re-disclosure 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 above.

Patient/ Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Address : \_\_\_\_\_

Phone: \_\_\_\_\_