CHILD CARE CONSULTANTS, INC.

Practice Limited to Pediatrics

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AUTHORIZATION TO TRANSFER MEDICAL RECORDS

TO CHILD CARE CONSULTANTS

Patient Name:_____

Date of Birth:_____

Social Security Number:_____

Transfer records to 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

From: Office / Other : _____
Address: _____
Phone # : _____ Fax# : _____

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's Address: _____ Phone : _____