Linda Guse, MD - Tamara Stone Iorio, MD - Scott Taylor, MD - Mary Chambers, MD - Michelle Richer, CPNP - Lindsey George, CPNP

# Authorization to Release Medical Records

**Date of Request:**_____

I am requesting records for ☐ myself or ☐ my child(ren).

Check here if requesting records from more than one patient & fill out the back: ☐

**Patient Name:** _____ **Date of Birth:** _____

Address: _____

City/State/Zip: _____

**Please Transmit Medical Records by ☐ Email ☐ Fax ☐ Mail**

Organization **PROVIDING** the information:

Name: _____
Address: _____
_____
Phone: _____
Fax:_____
Email:_____

Organization **RECEIVING** the information:

Name: _____
Address: _____
_____
Phone: _____
Fax:_____
Email:_____

Reason for request: ☐ Moving out of town ☐ Changing physicians ☐ New insurance
☐ Second opinion ☐ Educational testing ☐ Legal

Please include the following: ☐ All medical records ☐ Vaccine records only
☐ Health records for specific dates: _____
☐ Other records: _____

**I understand by signing this form, I authorize the release of my (or my child's) protected health information**

**Patient/Parent/Guardian Name:**_____**Relationship(Required):**_____

**Patient/Parent/Guardian Signature:**_____ **Phone:** _____

***Please note that Northside Pediatrics only releases records created by our office. Other records must be obtained directly from those locations. Patients transferring to another physician in our region will not be permitted to return to Northside Pediatrics.*

**4225 Vickers Drive Columbus, IN 47203 P: 812-379-9524 F: 812-376-6383 phonenurse@northside-pediatrics.org**

**Authorization to Release Medical Records – *Additional Patients***

## 2nd

**Patient Name: _____ Date of Birth: _____**

Address: _____

City/State/Zip: _____

**I understand by signing this form, I authorize the release of my (or my child's) protected health information**

**Patient/Parent/Guardian Name:_____Relationship(Required):_____**

**Patient/Parent/Guardian Signature:_____Phone: _____**

## 3rd

**Patient Name: _____ Date of Birth: _____**

Address: _____

City/State/Zip: _____

**I understand by signing this form, I authorize the release of my (or my child's) protected health information**

**Patient/Parent/Guardian Name:_____Relationship(Required):_____**

**Patient/Parent/Guardian Signature:_____Phone: _____**

## 4th

**Patient Name: _____ Date of Birth: _____**

Address: _____

City/State/Zip: _____

**I understand by signing this form, I authorize the release of my (or my child's) protected health information**

**Patient/Parent/Guardian Name:_____Relationship(Required):_____**

**Patient/Parent/Guardian Signature:_____Phone: _____**

## 5th

**Patient Name: _____ Date of Birth: _____**

Address: _____

City/State/Zip: _____

**I understand by signing this form, I authorize the release of my (or my child's) protected health information**

**Patient/Parent/Guardian Name:_____Relationship(Required):_____**

**Patient/Parent/Guardian Signature:_____Phone: _____**