AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM PEDIATRICS OF AKRON, INC.

300 Locust St. Suite 200
Akron, OH 44302
Phone: 330-253-7753
Fax: 330-253-4611

Patient's Name:_____ Date of Birth:_____

I authorize Pediatrics of Akron, Inc. to release medical records TO the party listed below:

_____
Doctor/Medical Group/Parent

_____
Address

_____
City/State/Zip Code

_____
Phone/Fax

Purpose for Release: __Moving to:_____ __Switching Physicians (Reason:_____)

__Insurance Change to:_____ __Other:_____

Name (please print):_____ Relationship to Patient:_____

Signature:_____ Date:_____
(If patient is over 18 years old, signature must be that of the patient)

****This form expires 6 months from date signed****