Record Release

(This form can only be used to transfer to Pediatric Care)

TO

Pediatric Care, Inc.

8250 Winton Road #103
Cincinnati, Ohio 45231
Phone: (513) 931-6357
Fax: (513) 728-4762

8752 Union Centre Blvd.
West Chester, Ohio 45069
Phone: (513) 682-5400
Fax: (513) 682-5403

Release From:

_____
Name/Clinic

_____
Address

_____
City State Zip

Release To:
Please Check one:

□ **Winton Road Office**

□ **West Chester Office**

Please release medical records on the following patient(s):

1._____ Date of Birth:_____

2._____ Date of Birth:_____

3._____ Date of Birth:_____

4._____ Date of Birth:_____

Parents' Names_____

Address_____
Street City State Zip

Phone Numbers: Home_____Work_____

Reason for Transfer_____

This form can only be used for the transfer of records to Pediatric Care and cannot be used to transfer records from our office.

_____ _____
Signature **Date**