

**Authorization for Release of Medical Records**

Westerville Primary Care  
300 Polaris Parkway  
Suite 2150  
Westerville, Ohio 43082  
(614) 533-3354

I hereby authorize \_\_\_\_\_, located at  
Physician's name (print)

\_\_\_\_\_  
Address City State Zip

to furnish my medical records to **Westerville Primary Care** at the address above for the purpose of continuity of care.

Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results except as specifically listed below:

\_\_\_\_\_

This authorization is effective now and will remain in effect until \_\_\_\_\_.

I understand that I have the right to receive a copy of this authorization.

\_\_\_\_\_  
Signature Date of signature

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Patient's Date of Birth

If not signed by patient, please indicate relationship to patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient