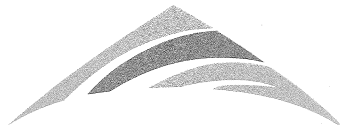

Ohio Surgery Center

930 Bethel Road
Columbus, Ohio 43214
(614) 451-0500
Fax (614) 451-2844

To Whom It May Concern:

I, ____________________________ request the release of physician and/or hospital medical records to Ohio Surgery Center.

I understand the information released will be used for the purpose of determining my care and will become a part of my permanent record. I authorize those portion(s) of my record deemed necessary by the physician caring for me to be faxed/mailed to the facility.

The undersigned hereby releases the above-mentioned from any liability that may arise from release and/or examination of the information indicated above.

Signed ____________________________ Date __________________
Patient or Responsible Party

Witness____________________________ Date __________________