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Pediatrician of Hyde Park

Authorization to Disclose Protected Health Information to Parents or Guardian of 18 years or older.

I understand that it is the policy of Pediatrician of Hyde Park to protect the privacy of all its patients and to follow all state and federal patient privacy laws. I hereby authorize Pediatric Care Inc. to disclose medical information about myself to my parent(s) or guardian(s).

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information.

I understand that I may revoke this Authorization at any time after I have signed it by providing a written statement that I wish to revoke this Authorization. (Please send all written revocations of Authorization to Pediatrician of Hyde Park. Attn: Medical Records, 3666 Paxton Avenue, Cincinnati, Ohio 45208. The revocation of my Authorization will be effective immediately upon Pediatrician of Hyde Park's receipt of the written revocation and my Protected Health Information can no longer be used/disclosed pursuant to this Authorization except to the extent of Pediatrician of Hyde Park has already taken action in reliance upon the validity of the Authorization.

I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws.

This Authorization shall remain in effect for as long as I am a patient at Pediatrician of Hyde Park. unless I choose to revoke it earlier in writing.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Patient's Signature Date

Patient's Cell# _____