THE PEDIATRICIANS OF HYDE PARK

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical release is a minimum of $30.00 and is due upon request.

Patient Name_____ Date of Birth ____/____/_____

Contact Numbers: ( )_____ ( ) _____

Patient Address: _____

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
☐ Pediatricians of Hyde Park 3666 Paxton Avenue Cincinnati, Ohio 45208	☐ _____ Organization/person _____ Street Address City, State, Zip _____ Phone

INFORMATION TO BE RELEASED

☐ Electronic ☐ Entire Record ☐ Billing Record ☐ Other (please specify) _____

Format for records (please check Only on box): ☐ MAIL ☐ PICK UP ☐ FAX

PURPOSE OF RELEASE

☐ Legal ☐ Personal use ☐ Continuing Care ☐ Transfer to another provider ☐ School ☐ Other: _____

AUTHORIZATION OF GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the discloser of this healthcare information is voluntary, I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Pediatricians of Hyde Park. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

The authorization will expire 90 days for the date signed below unless another date or event is entered here: _____.

(Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you).

Sensitive Records may require specific patient authorization, please check the applicable box below to request the following records. ☐ Drug/Alcohol abuse/treatment & diagnosis ☐ Sexually transmitted diseases ☐ Mental Health Treatment ☐ HIV/AIDS diagnosis/treatment/testing.

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

_____

Signature of Minor Patient Date

_____

Signature of patient or Legally Responsible Party Date

_____

Relationship to patient, if not signed by patient:

EVELYN C. JOSEPH, MD F.A.A.P. KATHLEEN LAMPING-ARAR, MD, F.A.A.P. EDWARD R. GARVIN, MD, F.A.A.P. ALYSSA PILJAN-GENTLE, MD, F.A.A.P. ALISSA M. GILBERT, MD, F.A.A.P. KARRY R. WILKES, MD, F.A.A.P.

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