



THE PEDIATRICIANS OF HYDE PARK, LLC

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:
<input type="checkbox"/> Pediatricians of Hyde Park, LLC 3666 Paxton Avenue Cincinnati, Ohio 45208	<input type="checkbox"/> _____ Organization/person Street Address _____ City, State, Zip _____ Phone _____

INFORMATION TO BE RELEASED

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 one year from the date signed below unless another date or event is entered here: _____.

**Sensitive Records Protected by CFR 42 (<https://www.samhsa.gov/newsroom/press-announcements/202007131330> require specific patient authorization to release, 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