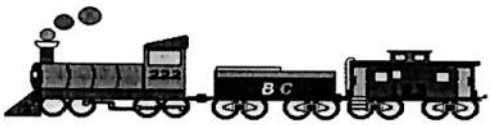

Pediatrics

THE PEDIATRICIANS OF HYDE PARK, LLC
3666 Paxton Avenue
Cincinnati, Ohio 45208
P: 513-871-0684 F: 513-871-0705
Email: pohp@pohp.pcc.com

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print)

Name: _____

Birthday: _____ Address: _____

Current Phone # (in case of questions): _____

Records From:

_____
MD or Group Name

_____
Mailing Address

_____
City, State, Zip Code

Records To:

_____
MD or Group Name

_____
Mailing Address

_____
City, State, Zip Code

Information Requested:

_____All Records ($30.00/record fee) _____Vaccines records (Patient Portal) _____Specific Dates

I hereby request and authorize the release of requested health care information from the above name party to the corresponding above-named part. This authorization will expire one year from the date signed. I have the right to revoke this authorization in writing at my discretion. My written revocation must be submitted to the Privacy Officer at The Pediatricians of Hyde Park, LLC.

_____ _____
Patient or Guardian and Relationship Date

Are you transferring to another practice? _____

**Our office is unable to release records from other practices. If you need a copy of records from your previous pediatrician's office, we suggest that you have the records sent to you and have a copy made for yourself. ** This is due to the National HIPAA Law. Thank you for understanding