WEST SIDE PEDIATRICS

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name** _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

**List where you want your current medical records to be SENT FROM:**

**The person named above authorizes information to be released by representatives of:**

Name of Person, Provider, or Facility _____
Address _____
Phone _____
Fax _____

**The person named above hereby authorizes** _____ **to**
Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☒ Send health information to
- ☐ Discuss health information with

**List where your current medical records are to be SENT TO:**

Name Of Person, Provider, Or Facility: West Side Pediatrics
Address: 663 Anderson Ferry Road, Cincinnati, OH 45238
Phone: 513-922-8200
Fax: 513-347-2407

**Scope**

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

**Authorization**

_____
Printed name of Patient or Authorized Representative

_____ (Signature of Patient or Authorized Representative) _____ (Date) _____ (Signature of witness) _____ (Date)

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

| Initial | Date | | From | To |
|---|---|---|---|---|
| _____ | _____ | Alcohol or Drug Use/Abuse Treatment | _____ | _____ |
| _____ | _____ | Mental Health Treatment | _____ | _____ |
| _____ | _____ | HIV Status or Treatment | _____ | _____ |

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge.