Hyde Park Pediatrics Authorization to Disclose Protected Health Information to Parents or Guardian of 18 years or older

I understand that it is the policy of Hyde Park Pediatrics to protect the privacy of all its patients and to follow all state and federal patient privacy laws.

I hereby authorize Hyde Park Pediatrics to disclose medical information about myself to the following individuals.

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Name | Phone Number | Relationship

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Name | Phone Number | Relationship

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 *Hyde Park Pediatrics, 3330 Erie Ave Suite 11, Cincinnati, Ohio 45208.* The revocation of my Authorization will be effective immediately receipt of the written revocation and my Protected Health Information can no longer be used/disclosed pursuant to this Authorization except to the extent Hyde Park Pediatrics has already acted 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 Hyde Park Pediatrics unless I choose to revoke it earlier in writing.

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Patient's Printed Name | Date of Birth

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Patient's Signature | Date