

Please be sure to complete all sections and check all applicable boxes. If you have any questions, please call Debbi @ 232-8100, ext. 3304 or option 6. All fees must be paid prior to records being released.



RECORDS RELEASE AUTHORIZATION

7400 Jager Court Cincinnati, OH 45230 Phone 513.232.8100 Fax 513.624.3191

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's home phone #: () _____
Date of Request: _____ Date Needed: _____

<input type="checkbox"/> I authorize Anderson Hills Pediatrics, Inc. to release information to (including myself): Name _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code) _____	OR	<input type="checkbox"/> I authorize Anderson Hills Pediatrics, Inc. to obtain information from: Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code) _____
---	-----------	---

PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Personal Attorney Research

TYPE OF RECORDS REQUESTED: (Check one.)

- All medical records
 - Immunization records, Last Physical Exam, Medication List – **No Charge**
 - Other, please specify _____
- Charges may apply. The Medical Records clerk will call with a fee amount, if applicable.

NOTE: THIS DOES NOT INCLUDE RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS. PLEASE CONTACT OTHER MEDICAL PROVIDERS TO OBTAIN COPIES OF THOSE RECORDS.

AUTHORIZATION VALID FOR: (Check one.)

- This request only.
- One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I release staff and counsel from all legal responsibility or liability that may arise from authorized release of information.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- This authorization will include the release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drugs or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric or psychological conditions.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (if requester is not the patient) _____

If transferring out of Anderson Hills Pediatrics, please state reason for leaving _____