Please be sure to complete all sections and check all applicable boxes. If you have any questions, please call Medical Records @ 513-232-8100. All fees must be paid prior to records being released.

RECORDS RELEASE AUTHORIZATION

Anderson Hills PEDIATRICS

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:** _____

☐ I authorize Anderson Hills Pediatrics, Inc. **to release information to (including myself)**:

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

☐ 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- **Charges may apply**

☐ Immunization records, Last Physical Exam, Medication List – **No Charge**

☐ Other, please specify_____.

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_____