FOREST HILLS PEDIATRICS, LLC

Office:(513)232-5512 Fax: (513)232-3341

AUTHORIZATION FOR WRITTEN RELEASE OF MEDICAL INFORMATION

Patient Name: __________________________________ Birth Date: _______________
Please Print

I, the undersigned, hereby authorize the release of the following information from my (or give relationship ________________________'s) medical record. This authorization includes release of information concerning treatment of drug abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, AIDS/AIDS related conditions and/or HIV testing. Review of the record is also authorized

The Following information is requested:
( ) Office /Progress Notes, medication list, and problem list
( ) Emergency Treatment(s) Hospitalization(s)
( ) X-ray films/diagnostic testing
( ) Entire medical record
( ) Limited to treatment dates and for conditions described below
( ) Immunization records and growth charts
( ) Other

REASON NEEDED

Please specify the reason for your request.
( ) Medical Care
( ) Legal Reasons
( ) Disability
( ) Insurance
( ) At My Request/Personal Reasons
( ) Other ____________________

I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be redisclosed by such person/entity and will likely no longer be protected by the federal privacy regulations. I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to Forest Hills Pediatrics, LLC. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

Send Records to: ________________________________
(Doctor)

____
(Address)

____

From: ________________________________
(Doctor)

____
(Address)

____

This authorization will expire in 60 days unless otherwise specified ____________________________

____
(Parent/Legal Representative)

____
(Date)

*Reason Patient is unable to sign ____
*Describe scope of authority to act for patient: __________________________________

____
Witness Signature

____
Date