Medical Records Release Authorization

Patient Name: _____ Date of Birth: _____

Information to be released **FROM**:	Information to be released **TO**:
☐ Hilliard Pediatrics, Inc. ☐ Organization/Person Name:	☐ Hilliard Pediatrics, Inc. ☐ Organization/Person Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone #:	Phone #:

Information to Be Released (Check all that apply)

☐ Entire Legal Medical Record - from _____ to _____

☐ Specific Information as Described Below:

Format of Request (If not selected, records will be sent in CD format)

☐ **CD (compact disc) of Medical Records** – Hilliard Pediatrics offers the option of getting your records on a compact disc free of charge for your first request. Additional requests will be charged a flat fee of $6.50 per request.

☐ **Printed Medical Records –** per page fee schedule based on current rates permissible under Ohio law 3701.741. This fee applies for all requests for printed copies.

* Note: fees listed above only apply to records being transferred from Hilliard Pediatrics to another healthcare provider. Records being transferred from another office to Hilliard Pediatrics will be charged in accordance to that practice's policies.

Purpose of Release

☐ Moving out of the area (please provide new patient address below)

☐ Transitioning to an adult practice	☐ Personal Use
☐ Legal	☐ School

☐ Other (please specify):

Authorization for General Release of Information

I understand that:

- If the person or entity to whom Hilliard Pediatrics Inc. is disclosing my information is not a doctor, healthcare provider, or health plan, the information may not be protected by HIPAA, and that person may use or disclose that information to other non-covered entities.
- Information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand that the revocation will NOT apply to information that has already been release in response to this authorization.
- Authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization and it will not affect my ability to obtain treatment from Hilliard Pediatrics, Inc.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Contact Number: _____