



Authorization for Use and/or Disclosure of Protected Health Information

This form authorizes ESD Pediatric Group to use an/or disclose protected health information in the manner described below and is voluntary. ESD will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.



Please note that each section of the form must be completed in its entirety. **Failure to specify (including dates) will delay the processing of your request.**

Patient Information	<p>Patient Name: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">Middle</small></p> <p>Patient Address: _____</p> <p>Date of Birth: _____ Phone: () _____</p> <p>Parent/Guardian/Requestor Completing Form: _____ <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">Middle</small></p> <p>Requestor Email Address (optional): _____ <small>Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.</small></p>																		
Release To	<p>Name: _____ Organization (if applicable): _____</p> <p>Street Address: _____</p> <p>City/State: _____ Zip Code: _____ Phone: () _____</p> <p>Information May Be: <input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Discussed via Telephone <input type="checkbox"/> In Person Meeting <input type="checkbox"/> Picked Up By: _____ <input type="checkbox"/> Verbal communication; no records needed</p> <p>Note: Please bring photo ID when picking up records from the office.</p> <p>I would like copies provided in the following format: Requestors will be sent a prepayment invoice upon Determination of total cost. <small>(Fees are reviewed and updated annually based on Ohio ORC 3701.742)</small></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Paper-</td> <td style="width: 25%; border: none;">First 10 Pages—</td> <td style="width: 25%; border: none;">\$3.11 per page</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Pages 11—50—</td> <td style="border: none;">\$0.65 per page</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Pages 50 & above—</td> <td style="border: none;">\$0.26 per page</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Related Postage—Actual Cost</td> <td style="border: none;"><small>(waived if picked up)</small></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> CD-</td> <td style="border: none;">\$2.13 per page</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Related Postage—Actual Cost</td> <td style="border: none;"><small>(waived if picked up)</small></td> </tr> </table> <p><small>Note: Charges are waived for records sent directly to continuing Care providers.</small></p>	<input type="checkbox"/> Paper-	First 10 Pages—	\$3.11 per page		Pages 11—50—	\$0.65 per page		Pages 50 & above—	\$0.26 per page		Related Postage—Actual Cost	<small>(waived if picked up)</small>	<input type="checkbox"/> CD-	\$2.13 per page			Related Postage—Actual Cost	<small>(waived if picked up)</small>
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	Related Postage—Actual Cost	<small>(waived if picked up)</small>																	
Purpose/Reason for Transfer	<p>Records are to be released for the following purpose (s): <small>(Select all that apply)</small></p> <p><input type="checkbox"/> Medical Care <input type="checkbox"/> Attorney/Legal <input type="checkbox"/> Personal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/SSI <input type="checkbox"/> Other: _____</p> <p>I am transferring my child for the following reason(s): <input type="checkbox"/> Child over 21 years of age <input type="checkbox"/> Financial Problems <input type="checkbox"/> Location Issues – Office is too far from work and/or home. <input type="checkbox"/> Care Issues (Please explain incident on back of form)* <input type="checkbox"/> Insurance change – Office is no longer an in-network provider. New insurance carrier: _____ <input type="checkbox"/> Inconvenient office hours</p>																		
Information To Release	<p>Dates of Treatment/Particular Illness Requested: _____</p> <p><input type="checkbox"/> Medical Record Abstract—Pertinent information generally used for continued care/personal use. <small>Generally the receiving caregiver only wants an abstract of pertinent information. This same abstract generally meets the need for individual use.</small></p> <p><input type="checkbox"/> History & Physical <input type="checkbox"/> X-Ray Reports, Labs or Other Tests <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Immunizations <input type="checkbox"/> Registration Sheets <input type="checkbox"/> Consultation Reports, Specify MD _____ <input type="checkbox"/> Outpatient Clinic Notes, Specify Clinic _____ <input type="checkbox"/> Other: _____</p>																		
Patient/Parent/Legal Guardian Authorization	<p>Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired) _____. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Practice Administrator at the address below. Please refer to ESD's Notice of Privacy Practices. If ESD requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.</p> <p>I, the undersigned, hereby authorize ESD to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This Authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity (ies).</p> <p>Signature of Patient (if 18 years of age or older OR is an emancipated minor): _____ Date: _____ Signature of <input type="checkbox"/> Parent / <input type="checkbox"/> Legal Guardian (check one): _____ Date: _____ <small>Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.</small></p>																		
Submit	<p>Please verify that all sections are completed in full. Upon completion, please send the form to:</p> <p>ESD Pediatric Group 905 Main Street/4000 Smith Rd., Suite 175 OR Fax the form to: (513) 248-3065 OR Email to: milford@esdpeds.com Milford, OH 45150/Cincinnati, OH 45209 (513) 533-6105 hydepark@esdpeds.com</p>																		

Request has been completed: YES, Initials _____ Date: _____