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.

STOP 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

Patient Name: _____ Gender: ☐ Male ☐ Female
Last First Middle

Patient Address: _____

Date of Birth: _____ Phone: ( ) _____

Parent/Guardian/Requestor Completing Form: _____
Last First Middle

Requestor Email Address (optional): _____
Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.

Release To

Name: _____ Organization (if applicable): _____

Street Address: _____

City/State: _____ Zip Code: _____ Phone: ( ) _____

Information May Be: ☐ Mailed ☐ Reviewed Only ☐ Discussed via Telephone ☐ In Person Meeting

☐ Picked Up By: _____ ☐ Verbal communication; no records needed

Note: Please bring photo ID when picking up records from the office.

I would like copies provided in the following format:

☐ 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 *(waived if picked up)*

☐ CD-
$2.13 per page
Related Postage—Actual Cost *(waived if picked up)*

Requestors will be sent a prepayment invoice upon Determination of total cost.
(Fees are reviewed and updated annually based on Ohio ORC 3701.742)

Note: Charges are waived for records sent directly to continuing Care providers.

Purpose/Reason for Transfer

Records are to be released for the following purpose (s): *(Select all that apply)*
☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Other: _____

I am transferring my child for the following reason(s): ☐ Child over 21 years of age ☐ Financial Problems
☐ Location Issues – Office is too far from work and/or home. ☐ Care Issues (***Please explain incident on back of form***)*
☐ Insurance change – Office is no longer an in-network provider. New insurance carrier: _____
☐ Inconvenient office hours

Information To Release

Dates of Treatment/Particular Illness Requested: _____

☐ Medical Record Abstract—Pertinent information generally used for continued care/personal use.
Generally the receiving caregiver only wants an abstract of pertinent information. This same abstract generally meets the need for individual use.

☐ History & Physical ☐ X-Ray Reports, Labs or Other Tests ☐ Office Visit Notes
☐ Immunizations ☐ Registration Sheets ☐ Consultation Reports, Specify MD _____
☐ Outpatient Clinic Notes, Specify Clinic _____ ☐ Other: _____

Patient/Parent/Legal Guardian Authorization

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.

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).

Signature of Patient (if 18 years of age or older OR is an emancipated miror):_____ Date:_____

Signature of ☐ Parent /☐ Legal Guardian (check one): _____ _____ Date:_____

Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

Submit

Please verify that all sections are completed in full. Upon completion, please send the form to:

ESD Pediatric Group
905 Main Street/4000 Smith Rd., Suite 175
Milford, OH 45150/Cincinnati, OH 45209

OR

Fax the form to: (513) 248-3065
(513) 533-6105

OR

Email to: milford@esdpeds.com
hydepark@esdpeds.com

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