Marysville Pediatrics, Inc.

610 S. Plum Street, Marysville, Ohio 43040
937-644-1920 FAX 937-644-2024

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name:_____ **DOB**_____

Physican/Organization authorized to DISCLOSE information:(from)
Name:_____
Address:_____
_____
Phone:_____ **Fax:**_____

Physican/Person authorized to RECEIVE the information:(to)
Name:_____
Address:_____
_____
Phone:_____ **Fax:**_____

RECORDS TO BE RELEASED

___**Entire record**_____
___**Vaccine Record, Growth Charts, Date of Last Wellness visit:**_____
___**Allergies, Medication List:**_____
___**Lab tests – Dates of Service:**_____
___**Radiology reports – Dates of Service:**_____
___**Other(please specify):**_____

PURPOSE OF THIS DISCLOSURE

___**Continuity of medical care** ___**At the request of the patient**
___**Pending legal action** ___**Insurance or other Third Party Reimbursement**
___**Other (please specify)**_____

I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal Privacy Regulations, the information described above may be disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that although Marysville Pediatrics, Inc., has a responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and the information may no longer be protected by Federal Privacy Laws or Regulations. Marysville Pediatrics, Inc., will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Marysville Pediatrics, Inc., of any liability, which may arise as a result of any subsequent disclosure of my health information by the recipient.

The authorization will remain valid for 60 days from today's date or at an earlier date, at my election. I understand that 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 my physicians's office, Marysville Pediatrics, Inc. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy.

SIGNATURE:
Patient or Legal Representative:_____ **Date:**_____

If signed by Legal Representative, relationship to patient:_____