THIS FORM MUST BE COMPLETED IN ITS ENTIRETY BY THE PATIENT OR THE PATIENT'S LEGAL GUARDIAN

FOREST HILLS PEDIATRICS, LLC
AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address/City/ST/Zip: _____

Phone Number: _____

I authorize:

Forest Hills Pediatrics, LLC
7495 State Road, Suite 335
Cincinnati, Ohio 45255

to use and/or disclose my/the patient's individually identifiable health information as described below.

I authorize the following person(s) or organization to receive the information:

Name (Previous Physician): _____

Street Address: _____

City/ST/Zip: _____

3. Type of Information to be released: Check the type of information that you want to be used or disclosed pursuant to this Authorization:

A. Medical Records: *CHECK ONE*
☐ **All medical records; *or***
☐ I **only want the parts of my medical record described below to be disclosed**:

_____

_____

B. Billing Records:
☐ A**ll billing records including itemized statements**

C. Dates of Treatment: *CHECK ONE*
☐ **All dates of treatment; *or***
☐ **I only want records for the following dates of treatment to be disclosed**:

_____

_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

2-sided document turn over

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Please check the reason for the use and/or disclosure of the information:

☐ Transfer care ☐ Patient's request ☐ Applying for Disability
☐ Applying for insurance ☐ Lawsuit/legal preparation ☐ Other:_____

Your refusal to sign this authorization: The Health Care Provider may not condition treatment, payment, enrollment in a health plan or eligibility for benefits, on whether or not you sign this Authorization. If you refuse to sign this Authorization the HealthCare Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

Expiration: This Authorization will expire one year after the date below, or sooner by choice, in which case this Authorization will expire on _____ . However, if the records to be used or disclosed pursuant to this Authorization concern psychiatric, psychological and/or mental health treatment, this Authorization will expire 90 days after the date below, or sooner by choice, in which case this Authorization will expire on _____ (If applicable, insert date on the foregoing line. Note: You may not indicate that there is no expiration; for example, the words "does not expire" or "no expiration" or "none" are not acceptable).

Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Health Information Management Department/Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that Health Care Provider took before it received my revocation letter.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

_____ _____
SIGNATURE OF WITTNESS **DATE**

Printed name of patient's representative, if applicable: _____

Relationship to patient (check box):
☐ Parent ☐ Legal Guardian ☐ Other: _____
***Legal documentation of Representative's authority must accompany this Authorization.

Please note that there may be a charge to copy records. ☐ Paper ☐ Flash Drive ☐ Picked up ☐ Mail

Ohio Practice: Ohio State Medical Board Regulation [§ 3701.74.1]
If you request a copy of your medical records you will be charged the following fees:
A) With respect to data recorded on paper, the following amounts apply:
i) $3.07 per page for the first ten (10) pages;
ii) $0.64 per page for pages eleven (11) through fifty (50);
iii) $0.26 per page for pages fifty-one (51) and higher
iv) $2.10 per page with respect to data resulting from X-ray, MRI, or CAT scan, recorded on paper or film
B) With respect to data recorded other than on paper (I.e. electronic copy):
i) Eight dollars ($8.00) per flash drive required
ii) The actual cost of any related postage incurred by Forest Hills Pediatrics