# Pediatric Physicians, Inc
# 3643 Ridge Mill Dr • Hilliard, Ohio 43026
# Phone: 614-771-0200 • Facsimile: 614-771-5267

## AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

Printed Patient's Name: ______________________________________________

Phone: _______________ Patient's Birthdate: ___________ Social Security Number: _____________

Person/Organization Authorized to Receive Information:
__________________________________________
__________________________________________
__________________________________________
__________________________________________

Previous Practice Sending Information/Phone Number
____________________________/______________

For the following dates of treatment (include specific description of information requested):
____________________________________________________________________________________________
________________________________________________________________________________________

For the purpose of:
(Optional)

_____ Further Medical Care
_____ Insurance Billing
_____ Legal Reasons
_____ Self
_____ Other (Please Specify) _____________________________________________

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 redisclosed to a third party and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed **under this authorization**. This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

Patient's Signature: _____________________________ Date: ____________________

Guardian/Legal Representative Signature:______________________________________

Witness: ____________________ _______________Date: ______________________

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. **This authorization will expire automatically 60 days from the date on which it is signed.** Cancellation of this authorization prior to the 60-day limit must be made in writing and sent to the address below:

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3643 Ridge Mill Dr.
Hilliard, Ohio 43026