

Pediatric Associates of Mount Carmel, Inc.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

to use and/or disclose certain protected health information (PHI) about me to:

Pediatric Associates of Mount Carmel
4420 Aicholtz Road
Cincinnati, Ohio 45245

This authorization permits _____ to use and/or
disclose the following individually identifiable health information about me: _____

The information will be used or disclosed for the following purpose: _____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to _____.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Date of Birth Printed Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

It is the policy of our office to release medical records for care provided in our office only by our physicians. Please allow two weeks for records to reach their destination.

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Batavia
2055 Hospital Drive
Suite #250
Batavia, OH 45103

Eastgate
4371 Ferguson Drive
Cincinnati, OH 45245
(513) 752-3650
(513) 752-3387 Fax

Loveland
10572 Loveland Madeira Rd.
Loveland, Ohio 45150