



9600 Children's Dr. #D
Mason, OH 45040

Authorization for Release and Consent to Request Medical Records

I, _____ hereby authorize Suburban Pediatric Associates, Inc. and its agents to release information
Parent or Guardian

regarding: _____

Name of patient and Date of Birth

Name of patient and Date of Birth

Name of patient and Date of Birth

Name of patient and Date of Birth (Check One) Release to Obtain from Discuss with

Name of Facility: _____ Telephone: _____

Address _____ City/State: _____ Zip Code: _____

Release of information from this health record is for the purpose of (check one):

- Moving
- Insurance change
- Switch to adult MD
- Closer Pediatrician
- Unhappy with care
- Other (explain) _____

Only pertinent information is to be obtained/forwarded/discussed and should include:

- SPA record summary (no charge) Complete copies of records
- (Includes: Immunizations, Last well check, Growth charts, Medications) \$1.00 per page for pages 1-10, \$.60 for 11-50 and \$.20 for each additional page in accordance with Ohio State Med. Assoc. recommendations
- Other _____

SPECIAL AUTHORIZATION FOR RELEASE OF RECORDS FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND OR DEPENDENCY, HIV ANTIBODY TESTS RESULTS AND/OR AIDS DIAGNOSIS AND TREATMENT.

Please initial all that apply, if the information is to be released.

- Include information related to diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Include information related to diagnosis and/or treatment for mental health/rehabilitation
- Include information related to HIV antibody test results and/or AIDS diagnosis and treatment

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the records/information requested on this form has been provided to the requestor.

Date: _____ Signature of Patient or Patient Representative _____

Print Name _____

Date: _____ Signature of Witness _____

Print Name _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from the records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

Date Processed: _____ Processed by: _____