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

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

Name of Facility: ____________________________________ Telephone: _____________________Fax:________________

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)
(Includes: Immunizations, Last well check, Growth charts, Medications)

☐ Complete copies of records
$3.18 per page for pages 1-10, $0.66 for 11-50 and $0.27 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: _______________________________

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