AUTHORIZATION TO RELEASE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

☐ Mason ☐ Sycamore ☐ Lebanon

PATIENT NAME: ____

DOB: ____

I authorize the disclosure and/or use of the individual health information for the above named patient and described below.

PARTY AUTHORIZED TO DISCLOSE AND USE INFORMATION
The information may be disclosed by ______________________________ and/or its affiliates and Business Associates. List if other:________________________

INFORMATION TO BE DISCLOSED AND USED
The type of information includes and is limited to the following:

1. ____ Complete copy of the chart including other facility records, records relating to psychotherapy, psychological assessment, psychiatric conditions, HIV testing and AIDS related conditions.

2. ____ Dates of treatment from __________ to __________

3. ____ Immunizations records

4. ____ Other (specify including dates) ________________

PARTY TO WHOM INFORMATION IS BEING DISCLOSED

The above information is to be released and disclosed to____

at the following location and address:____.

PURPOSE FOR DISCLOSURE AND USE OF INFORMATION

I authorize the release and disclosure of this information to____.

I understand the purpose of the disclosure is to ____.

RIGHT TO REFUSE REQUEST FOR AUTHORIZATION
I understand that I have the right to refuse to authorize the disclosure and use of this information. I also understand that Northeast Cincinnati Pediatric Associates, Inc. will not refuse to treat me or accept my enrollment for services as a result of my decision not to execute this Authorization.

RIGHT TO INSPECT INFORMATION DISCLOSED AND USED
I understand that I have the right to inspect the information which Northeast Cincinnati Pediatric Associates, Inc. is authorized to disclose as described above. I will forward a written request to Northeast Cincinnati Pediatric Associates, Inc. in order to exercise my right to review the information. I understand that Northeast Cincinnati Pediatric Associates, Inc. shall have 30 (thirty) days in which to respond to my request.

RIGHT TO REVOKE AUTHORIZATION
I understand that I have the right to revoke this Authorization prior to the expiration date which is noted below. I will forward a written request to Northeast Cincinnati Pediatric Associates, Inc. at 11643 Solzman Road, Cincinnati, Ohio 45249 which shall be effective to revoke this Authorization within 5 business days from the date of receipt of notice by Northeast Cincinnati Pediatric Associates, Inc. This revocation shall not operate to prohibit any disclosure and/or use of information previously provided prior to the effective date of revocation.

RIGHT OF ____ TO RE-DISCLOSE INFORMATION

I understand that the recipient of the information disclosed pursuant to this Authorization may re-disclose the information in conjunction with the stated purposes for which the information was originally authorized for release and use. I understand that ______________________________ may use this information for its necessary healthcare operations in addition to those purposes already stated in this Authorization.

EXPIRATION OF AUTHORIZATION

I understand that this Authorization will expire one (1) year from the Effective Date, as provided below. I understand that I may elect to renew this Authorization upon request by Northeast Cincinnati Pediatric Associates, Inc. by executing an Extension Addendum prior to the Expiration Date.

______________________________ ______________________________

Signature Date

____

Relationship to patient

____

Expiration Date

If transferring from Northeast Cincinnati Pediatric Associates, Inc.

Reason for transfer: ______________________________

Effective Date of transfer: ______________________________

REORDER # 0307311