PEDIATRIC ASSOCIATES OF MT. CARMEL, INC.
4371 Ferguson Drive Cincinnati, Ohio 45245
Phone: 513-752-3650
Fax: 513-752-3387

RECORDS RELEASE AUTHORIZATION

Patient's Name _____ Date of Birth _____
Address _____
City/State/Zip _____
Patient's Home Phone # _____
Date of Request: _____ **Date Needed:** _____

☐ I authorize Pediatric Associates of Mt. Carmel, Inc. to ***release information*** to (including myself):	☐ I authorize Pediatric Associates of Mt. Carmel, Inc. to ***obtain information*** from:
Name	Name
Address	Address
City/State/Zip	City/State/Zip
Phone#/Fax# (include area code)	Phone#/Fax# (include area code)

PURPOSE FOR THIS REQUEST: □ Healthcare □ Personal □ Attorney □ Other _____

TYPE OF RECORDS REQUESTES: (check one) ******PLEASE DO NOT FAX MEDICAL RECORDS******

☐ All Medical Records *

☐ Immunization records, Last Physical Exam, Medication List – **No Charge**

☐ Other, please specify *****_____

* Charges may apply. The Medical Records Clerk will call with a fee amount if applicable

NOTE: THIS DOES NOT INCLUDE RECORDS RECEIVED FROM OTHER HEALTHCARE PROVIDERS. PLEASE CONTACT OTHER MEDICAL PROVIDERS TO OBTAIN COPIES OF THOSE RECORDS.

AUTHORIZATION VALID FOR: (check one)

☐ This request only

☐ One year from the date of this authorization OR _____, (insert date) This authorization applies to the records of treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on authorization
- I may cancel this authorization at any time by submitting a ***written request*** to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I release staff and counsel from all legal responsibility or liability that may arise from authorized release of information.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated about could be re-disclosed.
- This authorization will include the release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric or psychological conditions.
- There may be a charge for the requested medical records.
- Any patient age 18 years or older will have to sign this release. Parent/Guardian cannot sign once your child has turned 18 years of age.

Signature of Patient or Representative _____ Date _____

Relationship to patient (if requestor is not the patient) _____

If transferring out of PAMC, please state reason for leaving _____