Springdale-Mason
PEDIATRIC ASSOCIATES, INC.

Authorization for Release of Health Information

This form authorizes Springdale-Mason Pediatric Associates, Inc. (SMP) to use and/or disclose protected health information in the manner described below and is voluntary. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information and is no longer protected by the federal privacy regulations.

Purpose of Request	Records are to be released for the following purpose(s): (please select the one that applies) ___ Transferring Medical Care ___ Medical Care other than transfer ___ Attorney/Legal ___ Verbal Communication with:_____ (Please check this option if you are filling this out to give us permission to speak with your parents)
Patient Information	Patient Name: _____ Date of Birth: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____
Release To	Name/Organization: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____ Information may be sent via: ___ US Mail ___ Picked up (Individual to Pick Up): _____
Release From	Name/Organization: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____
Information to be released	___ Entire Record (Standard two years of information, unless otherwise specified): _____ ___ Immunization Record ___ Growth Charts ___ Specific Office Visit: _____ ___ Test Results ___ Other: _____
Patient/Parent/Legal Guardian	Unless otherwise revoked, this Authorization will expire one (1) year from the date signed or, if specified on the following date: _____. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. To revoke the Authorization the patient/parent/legal guardian must submit a revocation request in writing to the address below. I, the undersigned, herby authorize SMP to use and/or disclose information from the medical or financial record as specified above. This authorization includes use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatrics/psychological conditions to the above-mentioned entity. **Signature of Patient**: _____ Date: _____ (if 18 years of age or older OR is an emancipated minor) **Signature of ___ Parent ___ Legal Guardian**: _____ Date: _____ Note: If Legal Guardian is checked, documentation establishing relationship must be provided, or on record in order to comply with this request. **Please print name of person signing release**:_____
Submit to	Verify that all sections are completed in full, signed and dated. Upon completion, please do one of the following: Mail or drop off the Completed form to: Springdale-Mason Pediatrics, 11360 Springfield Pike, Cincinnati, OH 45246 Fax the form to: Medical Records Department at (513) 782-3131