Montgomery Pediatrics, Inc.

10700 Montgomery Road, Ste. 100, Cincinnati, OH 45242 (513) 984-5552 Fax: (513) 984-5554
Form can be emailed to forms@montgomerypeds.com or officemanager@montgomerypeds.com

Authorization for Disclosure of Health Information

I, _____ hereby authorize Montgomery Pediatrics, Inc. and its agents to release information regarding:

_____ (Name of patient) _____ (Date of Birth)

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(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:

☐ Record summary (free of charge) Copy of last well child check, immunization records, and growth charts.

☐ Complete Medical records. There is a copying charge which is as follows: $25 for the first record transfer requested, and $10 for each additional child, unless otherwise determined (charts <10 pages may result in a lower fee), not to exceed $50. A $5 additional charge for postage is required if records are to be mailed. Mailed records are sent Priority Mail with Delivery Confirmation through U.S.P.S. Payment must be received before records will be released. Payment can be made at the time of pick up, by mail, or by phone (MC, VISA, AMEX, DISC). Once payment is received, please allow 2 weeks for copying and processing of your records.

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 _____