Montgomery Pediatrics, Inc.

9157Montgomery Road, Ste. 100, Cincinnati, OH 45242 (513) 984-5552 Fax: (513) 984-5554
Form can be emailed to forms.mpi@gmail.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 copied and 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 2-4 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 _____

Again, once payment is received, records will be processed. Please allow 2-4 weeks for copying of your records.