

**AUTHORIZATION TO RELEASE INDIVIDUALLY IDENTIFIABLE  
HEALTH INFORMATION**

Landen

Blue Ash

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 Northeast Cincinnati Pediatric Associates, Inc. and/or its affiliates and Business Associates.

**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 11238 Cornell Park Drive, Cincinnati, Ohio 45242 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: \_\_\_\_\_