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: _____