PEDIATRIC ASSOCIATES OF MT. CARMEL, INC.
4371 Ferguson Drive Cincinnati, Ohio 45245
Phone: 513-752-3650
Fax: 513-752-3387

RECORDS RELEASE AUTHORIZATION

Patient's Name _____ Date of Birth _____

Patient's Address_____City_____Zip_____

Patient's Home Phone # _____

Date of Request: _____ **Date Needed:** _____

Release Records From:	Release Records to:
Name	Name
Address	Address
City/State/Zip	City/State/Zip
Phone#/Fax# (include area code)	Phone#/Fax# (include area code)

PURPOSE FOR THIS REQUEST: □ Healthcare □ Personal □ Attorney □ Transferring out of PAMC, please state reason for leaving:

_____

TYPE OF RECORDS REQUESTS: ***(CHECK ONLY ONE)*** ******PLEASE DO NOT FAX MEDICAL RECORDS******

□ All Medical Records * (standard two years of information, unless otherwise specified).
□ Immunization records, Last Physical Exam, Medication List *
□ Other, please specify:
Provider to Provider Communication for Mental Health
*Charges may apply.

AUTHORIZATION VALID FOR:
□ One year from the date of this authorization OR _____, (insert date) This authorization applies to the records of treatment received on or prior to the date of this authorization.

I understand that I may cancel this authorization at any time by submitting a ***written request*** to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. My right to healthcare treatment is not conditioned on authorization. I release staff and counsel from all legal responsibility or liability that may arise from authorized release of information. If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated about could be re-disclosed. This authorization will include the release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric or psychological conditions.

Print Name: _____ Relationship to Patient_____

Signature of Patient or Representative _____Date_____
*Any patient age 18 years or older will have to sign this release. Parent/Guardian cannot sign once patient is 18 years of age.