ABC PEDIATRICS OF OHIO

616 Willard St, Washington Court House, Ohio 43160

Phone: 740 335 0886 Fax: 740 335 1924

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Childs Legal Name: (First Name – MI- Last) _____

Address: _____City_____St_____Zip_____

Birth date: _____SSI_____

Phone: _____

Please check one:

_____ Authorize ABC Pediatrics of Ohio LLC to **RELEASE** information to:

Name of Provider: _____

Address: _____

Phone and Fax number: _____

_____ Authorize ABC Pediatrics to **OBTAIN** information from:

Name of Provider: _____

Address: _____

Phone and Fax number: _____

Purpose for this request: (check one)

_____ **Copy of patient's entire medical record**

_____ Immunization History

_____ Medical records related to a specific illness or injury _____

Specific illness/injury

_____

_____

This information authorizes the release of protected health information that may include diagnosis and treatment pertaining to psychiatric conditions, alcohol or substance abuse, sexual assault/victimization records, acquired immunodeficiency syndrome (AIDS) or test for infection HIV

I Understand that:

- **This authorization if valid for 12 months from the date of signature**
- **I may cancel this authorization at any time by submitting a written notification**
- **If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed**

Print Name:_____**Signature** _____ **date:**_____