# Authorization to Release Medical Records

3330 Erie Ave, Cincinnati, OH 45208
7720 Montgomery Rd, Cincinnati, OH 45236
PHONE: (513)321-0199 FAX: (513)979-0569
EMAIL: medrecords@hydeparkpeds.com

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number _____

City/State/Zip Code: _____

**Date of Request:** _____

| | | |
|---|---|---|
| □ I authorize Hyde Park Pediatrics **to release information to*:** | **OR** | □ I authorize Hyde Park Pediatrics **to obtain information from:** |
| Name: _____ | | Name: _____ |
| Address: _____ | | Address: _____ |
| City/State/Zip: _____ | | City/State/Zip: _____ |
| Phone: (____) _____ Fax: (____) _____ | | Phone: (____) _____ |
| Email: _____ | | Fax: (____) _____ |

Patient or Representative Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

**If transferring out of Hyde Park Pediatrics, please state reason for leaving:** _____

*There is a $15 fee per child for records transferred OUT. The payment needs to be made before records are sent. Please call the office to make payment by phone or mail a check with the form.

Med Records ____ Bill ____ Triage ___ Mgr ____ Med Rec ____