Authorization to Release Medical Records

3330 Erie Ave, Cincinnati, OH 45208
7661 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 ____