# Pediatric Associates, Inc.

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## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

- ☐ **CD (Compact Disc) of Medical Records:**
  - ➢ We offer the option of getting your records on compact disc for a ***flat fee of $25 per patient***; payment due up front. This is easily transferable to your next provider and allows you to print off your records as needed. If you are a state funded health plan (i.e. Medicaid, CareSource, Molina), you may not receive this option unless you sign a liability form.
  - ➢ *CD's may be picked-up at any location or mailed to patients for an additional charge for First Class postage*
- ☐ ***Printed Medical Records-***per page fee schedule based on current rates permissible under Ohio law 3701.741*
- ☐ ***Immunization Records-***no charge*
- ☐ ***Specific Medical Info from Date of Service:**_______________*-per page fee schedule applies*

***PLEASE NOTE THAT ALL RECORDS PRIOR TO JUNE OF 2003 ARE IN STORAGE AND ADDITIONAL FEES ARE REQUIRED TO RETRIEVE THESE RECORDS. IF YOU ARE IN NEED OF THESE RECORDS PLEASE CALL OUR OFFICE BEFORE COMPLETING THIS FORM.***

**** PAYMENT FOR MEDICAL RECORDS MUST BE RECEIVED IN FULL BEFORE RECORDS WILL BE PROCESSED ****

**FOR:** Patient's Full Name: ________________________ Date of Birth: __________

Address: ____________________________________________

City: ________________ State: _____ Zip: ________ Phone: ______________

Father's Full Name: ____________________________________

Mother's Full Name: ____________________________________

*Please also list Mother's maiden name or alternate last names used while patient was being seen.

**BILL TO:** Name: ____________________ Address: ______________________

City: ________________ State: _____ Zip: ________ Phone: ______________

**MAIL TO:** Name: ____________________ Address: ______________________

City: ________________ State: _____ Zip: ________ Phone: ______________

**Pediatric Associates is sad to see you leave:** At Pediatric Associates, we strive to provide your family with quality healthcare and compassion. Because we value each one of our patients, we are interested to know why a family moves on. Please take a moment to fill out the section below, checking all the boxes that apply, and feel free to make additional comments on the back.

- ☐ Moving out of area
- ☐ Dissatisfaction with medical care
- ☐ Dissatisfaction with service from staff
- ☐ Access to appointment/appointment availability
- ☐ Outgrown need for Pediatrician
- ☐ Billing Problem
- ☐ Other

I understand that if the person or entity to whom Pediatric Associates, Inc. is disclosing my information is not a doctor, health care provider or health plan, the information may not be protected by HIPAA, and that person my Use or Disclose that information to other non-covered entities. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment from Pediatric Associates, Inc. I understand I have the right to inspect or copy information Disclosed by this Authorization. I understand I may revoke (cancel) this Authorization at any time. Revocation must be in writing. I understand that Pediatric Associates, Inc. cannot be held responsible for having Disclosed information in reliance on this Authorization before receiving a written revocation. I authorize Pediatric Associates, Inc. to disclose protected health information as described in this Authorization, and I understand that Pediatric Associates, Inc. is released from legal responsibility or liability for disclosing protected health information authorized by my signature below. I acknowledge I had an opportunity to ask questions before I signed and that I may receive a copy of the signed Authorization.

Patient/Guardian Signature: ______________________________ Date: ________

Printed Name: ____________________________________ Date: ________

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