Muddy Creek Pediatrics

Your Kids. Our Kids.

AUTHORIZATION FOR RELEASE AND CONSENT TO REQUEST PROTECTED HEALTH INFORMATION

In order to comply with State and Federal Regulations it is the policy of Muddy Creek Pediatrics to obtain authorization to release protected health information from the custodial parent and/or legal guardian of our minor (under the age of 18) patients. Patients who have reached the age of 18 must sign authorization for release and consent to request protected health information unless they are unable to sign on their own behalf and a parent or third party is the legal guardian. Proof of guardianship will be required for children over 18.

I, _____ hereby authorize Muddy Creek Pediatrics, LLC and its agents to release protected health information for the following:

Patient Name: _____ Date of Birth: _____
(Please print first name, middle initial, and last name)

FROM: (Name, address, and phone number of Facility records are being obtained from.)	**TO: (Name, address, and phone number of facility records are being released to.)**
_____ Street Address	_____ Street Address
_____ City, State, and Zip Code	_____ City, State, and Zip Code
_____ Phone Number	_____ Phone Number

Only pertinent information is to be obtained, released, or discussed and should include (please check all that apply):

_____ Muddy Creek Pediatrics Summary
Includes: Copy of last well child check, Immunization Record, and Growth Charts. There is a $5.00 administration fee to research and release a summary of records.

_____ Complete Copy of Records.
Fee will be based on Ohio Revised Code 3701.741. The fee schedule can be accessed by visiting http://codes.ohio.gov/orc/3701.741.

SPECIALIZED AUTHORIZATION TO RELEASE OR CONSENT TO OBTAIN RECORDS FOR MENTAL HEALTH, REHABILITATION, ALCOHOL OR SUBSTANCE ABUSE AND/OR DEPENDENCY, HIV ANTIBODY TEST RESULTS AND/OR TREATMENT MUST ALSO BE OBTAINED. PLEASE CHECK ALL THAT APPLY.

_____ Include information related to the diagnosis and/or treatment for mental health/rehabilitation.

_____ Include information related to the diagnosis and/or treatment of alcohol or substance abuse or dependency.

_____ Include information related to the diagnosis and/or treatment of HIV antibody test and/or AIDS.

I hereby release Muddy Creek Pediatrics, LLC employees and agents from any and all liabilities for fulfilling the authorization request for release of protected health information. I understand this consent is revocable by me in writing at any time except to the extent that action has been taken in reliance on it. I also understand that my signature below provides authorization to release and consent to obtain protected health information and that this consent will expire either ninety (90 days) after the date of this signature or automatically when the protected health information has been provided as requested above.

_____
Signature of the patient or patient's legal guardian/custodial parent Date

_____
Witness Signature Date

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from the records whose confidentiality is protected by law. Any further disclosure is strictly prohibited without additional written consent.