Wadsworth
PEDIATRICS

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS
TO: WADSWORTH PEDIATRICS

Patient Name: ____
Last First Middle (any previous name/aka)

Patient date of birth: ___/___/___ **Patient Phone: (   )**

Patient Address: ____
Street Address City State Zip

Release FROM:
Name/Organization: ______________________________
Address: ____
Street Address City State Zip
Phone: (   ) ____________ Fax: (   ) ____________

Purpose of Release (check all that apply):

☐ Transfer of Patient Care ☐ Specialist/Consultant's Notes ☐ ER/Urgent Care Visit Notes ☐ Lab/Radiology results

Format of records to be released (check all that apply):

☐ Paper (preferred by Wadsworth Pediatrics) ☐ PDF (on CD/DVD/USB jump drive) ☐ Verbal communication

Information May be Sent to Wadsworth Pediatrics Via:

☐ Mail Delivery to: **Wadsworth Pediatrics**
1225 High Street
Wadsworth, OH 44281

☐ Fax to: **(330) 334-8309**

Dates of Treatment Requested: from: ___/___/___ to: ___/___/___

Information to be released (check all that apply):

☐ **Medical Record Abstract** (ideally to include, but not limited to: Summary of Medical/Surgical History, Active Problem List, Current Medications, Immunization Record, Growth Charts)

Other Information Requested: ☐ Radiology Reports ☐ Laboratory Results ☐ Pathology Reports

Acknowledgement

This authorization expires **one year** from the date of signature, or on this date: ___/___/___
I understand that my /my child's/ my ward's medical record might have information about sexually transmitted diseases (STD's), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release my records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and that this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing at the institution to which this request was originally submitted.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health iformation.

______________________ ______________________ ___/___/___
Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**

My relationship to the patient is:

☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

______________________ ______________________ ___/___/___
Signature of Witness **Printed Name** **Date**