

SPRINGBORO PEDIATRICS, INC.

8 Sycamore Creek Drive
Springboro, Ohio 45066
Phone: 937 748-KIDS (5437)
Fax: 937 748-5434

Brian Esselstein, M.D.

Charles Hutchison, M.D.

Nalini Aggarwal, M.D.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

I, the undersigned patient or legal representative, hereby authorizes _____
Provider or Group Name

_____ Address _____ Phone #

to release my entire medical record or designated portions in Provider's possession to:

Springboro Pediatrics, Inc.
8 Sycamore Creek Dr.
Springboro, OH 45066

Phone# 937-748-5437
Fax# 937-748-5434

for all dates of service indicated.

I understand that my decision to sign this form is voluntary, and Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand I may revoke this authorization in writing at any time by following the directions in Provider's Notice of Privacy Practices, except to the extent that Provider has already acted based on this authorization.

I understand this authorization shall expire, without my express revocation, 60 days from the date written below. I understand that the information disclosed under this authorization may no longer be protected by HIPAA privacy regulations and may be subject to re-disclosure by the recipient. A photocopy or facsimile of this form shall be valid as the original.

Dates of Service for Request: _____

This release is being made at my request for the purpose of transferring my care.

This release is being used for continuity of care.

The entire Medical Record is being requested.

OR

The following portions of the medical Record are being requested:

Immunizations only History & Physical Progress Notes X-ray Reports

Labs (incl. HIV) Medications Mental Health Pathology Report

Chemical/Alcohol Tests and/or Dependency Records All Reports

Other: _____

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Social Security Number: _____

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE-DESCRIBED DISCLOSURE

Signature: _____ Date: _____

Patient (18 years or older) or patient's legal representative

Printed Name: _____

Address: _____ Phone: _____

if different than above

Legal representative is authorized to act for the patient as the patient's:

Parent Legal Guardian Health Care Representative Other: _____