Emerald Pediatrics
5695 Innovation Drive, Suite 100
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please allow 10 working days for this request to be processed

Patient Name _____ Date of Birth _____/_____/_____

Authorizes Emerald Pediatrics to release the following medical information to: (Include Name, Address and Phone #)

_____

_____

_____

Please be sure that your account with our billing office is up-to-date before requesting release of records

FEES:

❒ **Flash Drive:** Flat fee of $10 per patient for records on a flash drive; payment due up front.
❒ **Printed Records:** Fees are per page based on current rates permissible under Ohio Revised Code 3701.741
❒ **Immunization Records only:** No charge
***State funded health plans (Medicaid or CareSource):** Fees do not apply.

This request and authorization applies to:

_____ Health care information related to the following treatment, condition, or dates of treatment:
_____

_____ Transfer of medical care to new practice/change of doctor

Reason for transfer: _____ Moving out of area _____ Insurance _____Other

If other please explain:_____

Forwarding Address: _____

This authorization is valid for 60 days from the date of signature and there may be fees to process it. The patient can revoke this authorization at any time by notifying Emerald Pediatrics in writing. This would not affect any actions already taken by Emerald Pediatrics based upon this authorization.

I understand that once my/my child's records are released from Emerald Pediatrics, they are no longer considered a patient of Emerald Pediatrics and I must seek care with my/my child's new physician.

I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do not have to sign it to receive health care when the purpose is to create health information for a third party or take part in a research study.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. The privacy laws may no longer protect it.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS WILL BE RELEASED UNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

_____

Signature of patient or patient's authorized representative Date signed

FOR OFFICE USE ONLY

❒ **Billing Office Balance Due:_____** ❒ **Statement Attached/Sent Initials:_____**
❒ **Reviewed by Physician Physician Initials_____ Date:_____**
❒ **Records mailed/picked up Date:_____** ❒ **Fee amount paid: _____**