River's Edge Pediatrics, Inc.
Authorization for Release of Protected Health Information (PHI)

A Parent/Guardian or otherwise authorized requester must complete this form to receive any medical records. For copies of our child's medical records, we offer a couple of options to meet individual needs. Please select ***one.***

□ **Immunization Record**: available free of charge.

□ **Complete Medical Record**: $20 flat fee per patient. Payment is due at the time of the request and we ask 7-10 business days processing time.

*A release of records form must be completed ***per patient.*** *

FOR: Patient Name: _____ Date of Birth: _____

Patient's Home Address: _____

City: _____ State: _____ Zip: _____ Contact # ( ) _____

Release to: River's Edge Pediatrics, Inc.
4335 W. Dublin-Granville Road
Dublin, Ohio 43017

OR

_____
_____
_____

At River's Edge Pediatrics, Inc. we strive to provide your family with quality healthcare and compassion. We value each one of our patients! We are curious to know why a family is moving on. Please take a moment to complete the section below, checking all boxes that apply to your circumstances. We welcome an additional feedback you are willing to provide – please leave this information on the back of this form.

□ Moving out of the area
□ Access to appointments
□ Billing problem
□ Change in insurance coverage
□ Dissatisfaction with medical care
□ Dissatisfaction with service from staff
□ Outgrown need for Pediatrician
□ Other: _____

I understand that if the person or entity to which River's Edge Pediatrics, Inc. is disclosing my information to is not a doctor, health care provider or health plan, the information may not be protected under HIPAA and further, that person may use or disclose that information to other non-covered entities. I understand that the information in my health record may include information relating to substance abuse, behavior and mental health services, or HIV/AIDS. 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 River's Edge Pediatrics, Inc. cannot be held responsible for having disclosed information in reliance on this Authorization before receiving written revocation. I authorize River's Edge Pediatrics, Inc. to disclose Protected Health Information (PHI) as described in this Authorization, and I understand that River's Edge Pediatrics, Inc. is released from legal responsibility or liability for disclosing PHI 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.

_____

Signature of Patient or Parent/Guardian/Authorized Requester **Date**

_____

Printed Name **Date**