Authorization to Release Protected Health Information

A Parent/Guardian or otherwise authorized requester must complete this form to receive any medical records beyond an Immunization Record. For copies of your child's medical records, we offer several options to meet individual needs.

- ☐ **Immunization Records:** available *free* of charge. Immunization Records are available to you 24/7 via our Patient Portal. We ask for 24 hours to complete your request in office.
- ☐ **Medical Summary (MS):** *$5 flat fee per patient.* MS is a comprehensive summary of care including appointment dates, allergies, diagnoses, immunizations, & medications. MS may vary by patient.
- ☐ **Complete Medical Records, CD (compact disc):** *$20 flat fee per patient.* Payment is due at time of request & we ask for 7-10 days processing time. We offer the option of getting records on CD because it is easily transferable to another provider & allows you access to information as needed.
- ☐ **Complete Medical Records, printed:** *per page fee schedule* based on Ohio Revised Code 3701.741.
- ☐ **Specific Medical Information from Date of Service ___________:** *per page fee schedule*

*** PAYMENT FOR MEDICAL RECORDS MUST BE RECEIVED IN FULL BEFORE RECORDS WILL BE PROCESSED ***

FOR: Patient's Full Name: ____ Date of Birth: ________________
Patient's Home Address: ____
City: _____________________ State: _____ Zip: __________ Contact #: (   ) ________________
Father's Full Name: ____
Mother's Full Name: ____

BILL: Name: ____ Address: ________________________________
City: _____________________ State: _____ Zip: __________ Contact #: (   ) ________________

MAIL: Name: ____ Address: ________________________________
City: _____________________ State: _____ Zip: __________ Contact #: (   ) ________________

Mill Valley Pediatrics, Inc. is sad to see you leave. At MVP, we strive to provide your family with quality healthcare and compassion. We value each one of our patients as part of our MVP family. 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. Please feel welcome to leave additional notes or comments on the back.

- ☐ 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 Mill Valley 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 STDs, HIV, or AIDS. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment from Mill Valley Pediatrics, Inc. 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 Mill Valley Pediatrics, Inc. cannot be held responsible for having disclosed information in reliance on this Authorization before receiving a written revocation. I authorize Mill Valley Pediatrics, Inc. to disclose Protected Health Information (PHI) as described in this Authorization, and I understand that Mill Valley 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 Parent/Guardian/Authorized Requester: ______________________________ **Date:**__________

Printed Name: ____ Date: __________