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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Montgomery Pediatrics, Inc. and its agents to Release Obtain Discuss information regarding:

_____ (Name of Patient) _____ (Date of Birth)

FROM / TO / WITH

_____ (Name of Facility) _____ (Telephone)
_____ (Address) _____ (Fax)
_____ (City, State, Zip) _____ (Email)

This release of information is for the purpose of:

- Transferring care to Montgomery Pediatrics, Inc. Transferring care to another facility

Type of Request

- Record Summary Complete Medical Record Immunizations only
- Last well visit note, Immunizations, Growth charts - Well/pertinent visit notes, Medication and Allergy lists, Immunizations, Growth charts

All record requests require 30 days from receipt of payment to process. Expedited requests require 5 days from receipt of payment. Complete medical records are provided electronically once per calendar year at no charge. **Additional requests within the calendar year are \$25.** Record summaries are provided electronically free of charge with no limit.

There is a \$25 fee for all paper copies of complete medical records or record summaries. Paper copies requested to be mailed are subject to an **additional \$10 postage fee.** Records are mailed via USPS Priority Mail with Delivery Confirmation. Families who request paper records for multiple children will only be subject to one postage fee.

Please mail my records for an additional \$10 fee: _____ (Initials)

Please expedite my request for an additional \$25 fee: _____ (Initials)

Special Authorization for release of records: (Initial all that apply)

_____ Information related to diagnosis and treatment for alcoholism and/or drug abuse or dependency

_____ Information related to diagnosis and treatment for mental health/rehabilitation

_____ Information related to HIV antibody test results and/or AIDS diagnosis and treatment

*I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand that this consent is revocable by me, in writing, at any time except to the extent that action as been taken in reliance on it. I also understand that this consent **will expire either ninety (90) days after the date of this signature or automatically** when the records/ information requested on this form have been provided to the requester.*

_____ (Date)

_____ (Signature of Patient/Representative)

_____ (Printed Name of Patient/Representative)

_____ (Relationship of Representative)